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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for

February 22, 1984

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on the Wednesday, the  
22nd day of February, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

P.S.A. LAMEK, Q.C.)	Commission Counsel
E. CRONK )	
D. HUNT )	Counsel for the Attorney
L. CECCHETTO )	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I. J. ROLAND )	Counsel for The Hospital for
R. BATTY )	Sick Children
B. PERCIVAL, Q.C. )	Counsel for The Metropolitan
D. YOUNG )	Toronto Police
K. CHOWN	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
E. MCINTYRE	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children
H. SOLOMON	Counsel for The Ontario
	Registered Nursing Assistants

(Cont'd)...








APPEARANCES: (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
M. ROSENBERG	Counsel for Sui Scott - Nurse
J. A. OLAH	Counsel for Janet Brownless - R.N.A.
B. KNAZAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
F. J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W. W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)



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--- on commencing at 10:55 a.m.

THE COMMISSIONER: We will proceed directly to quarter to one without a break and most counsel have<sup>been</sup>/warned of that. At quarter past two I will have a statement to make with respect to the complaints of the Attorney General and the Metropolitan Toronto Police with respect to Miss Kitley and her client.

Yes, all right. Now, Mr. Hunt, I believe you were up.

KATHLEEN COULSON, Resumed

CROSS-EXAMINATION BY MR. HUNT (Continued):

Q. I only have a couple of areas really to deal with you this morning, so I will be very brief.

The first one has to do with the relationship between Susan Nelles and Phyllis Trayner. Now we have heard a month or so ago from Carol Browne with respect to that. She said essentially that between the two of them there was a conflict and that it essentially involved the problem of trusting each other, respecting each other's role and delegating authority.

Now, do you agree with that or is that your observation of any conflict that existed







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between them?

A. I was aware of conflict, but to my recollection I can't be specific as Carol was.

Q. Well the conflict I take it was something that was known to most of the people who were connected with that ward in any capacity.

A. I would agree to that.

Q. And whatever the source of it was, from your point of view, were there any other two nurses that had the type of conflict that everybody was aware of, such as they did?

A. Do you mean on that ward?

Q. Yes.

A. Not that I remember.

Q. Can I suggest to you for your comment that when, on the night of March 24th when you had your conversation with Lynn Johnstone, it came to your mind that a suspect was Phyllis Trayner one of the factors that caused that come to your mind along with others that you mentioned yesterday was the fact of this unusual conflict that existed between the two?

A. No.

Q. I think yesterday you said that there were -- what brought that to your mind was all of the concerns that you had had over the last







1  
2 nine months when you reviewed the situation in your  
3 mind, concerns you had about specific deaths; is that  
4 fair?

5 A. You said all the concerns?

6 Q. Yes. I think yesterday you  
7 suggested that what caused you to speculate on Phyllis  
8 Trayner that night was it was really all of the con-  
9 cerns that you had had when you reviewed these deaths  
10 over the nine-month period; it was really the  
11 combination of all of those as opposed to any one  
12 particular factor.

13 MS. McINTYRE: Sir, if Mr. Hunt is  
14 going to refer to the witness' evidence from yesterday,  
15 I suggest he put the specific evidence to her.

16 MR. HUNT: That is a fair request  
17 but I don't have it.

18 THE COMMISSIONER: What do you want to  
19 do?

20 MR. HUNT: Obviously I am in trouble.  
21 Why don't I just ask the witness what  
22 was the basis that caused that to spring to mind.

23 A. I'm sorry, would you repeat  
24 that.

25 Q. On the night of the 24th --

A. Yes.





1  
2 THE COMMISSIONER: You can't object  
3 to that question.

4 MS. MCINTYRE: I didn't mean to cause  
5 him so much trouble, sir.

6 MR. HUNT: Embarrassment and trouble,  
7 I get used to it.

8 THE COMMISSIONER: The only thing  
9 you can accuse him of is repeating unnecessary  
10 questions.

11 MR. HUNT: Q. I guess what I am  
12 getting at, and I would just say it to you and you  
13 can comment on it, this sort of controversy or con-  
14 flict that existed between the two of them is something  
15 that everybody who has testified here seems to have  
16 been aware of. As you say it seemed to be unique on  
17 that ward in the sense that they were the two that  
18 had it and there was no other similar type of relation-  
19 ship in existence between nurses on that ward.

20 Was this a factor that caused you to  
21 speculate in the way you did on the night of the 24th,  
22 along with whatever other concerns you had about  
23 certain of the deaths and who was present?

24 A. I was not aware of any other  
25 conflict on the floor. That is not to say there  
wasn't conflict between people. That was not







1  
2 uppermost in my mind and to the best of my recollection  
3 it did not seem to stand out when I made that comment.

4 Q. Now one of my friends put  
5 to you yesterday a series of questions about other  
6 people that you might encounter from time to time in  
7 the corridors and stairways of the Hospital at night.  
8 I think the list included, in addition to doctors and  
9 nurses, people from Housekeeping, the people who  
10 collected the garbage from the floors, the blood bank  
11 collector, the person who picked up the Narvel sheets,  
12 the security officer and the occasional visitors and  
13 physical plant people.

14 Do you recall that line of  
15 questioning?

16 A. I remember talking about  
17 various people in the Hospital.

18 Q. Now what I want to ask you  
19 though is, aside from doctors and nurses, if you saw  
20 people from Housekeeping and people collecting the  
21 waste and the blood bank people, people who were  
22 interested in the Narvel sheets or security officers,  
23 occasional visitors and physical plant people in the  
24 infants' rooms and near the IV apparatus, is that  
25 not something that would be highly suspicious?

A. These people are never in







1  
2 the rooms. The only person that would be in the  
3 infants' rooms would have been someone from Plant  
4 and Engineering if there was a problem, and if he was  
5 there, the nurse would be with him. So this definitely  
6 would stand out.

7 Q. Now when you did your own  
8 retrospective analysis of the events, and this would  
9 be coming up to the period of the night of the 24th  
10 of March, leading up to your conversation with  
11 Lynn Johnston, is it fair to say that in looking at  
12 all of the things that concerned you over that period  
13 leading up to the point where you speculated as to  
14 who might be the suspect of a Homicide investigation  
15 the category of personnel that first came to your  
16 mind was that of a nurse?

17 A. Yes.

18 Q. And we have heard from Carol  
19 Browne, again before Christmas, and she indicated that  
20 she had told the police, and this is after the events  
21 when she was discussing the matter with them after  
22 the preliminary hearing, that she had difficulty  
23 accepting the fact that if some of these children  
24 were intentionally being killed with an overdose that  
25 it could be anyone other than someone connected with  
nursing. Now, do you agree with that; disagree with





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it, or have any comments on it?

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MS. McINTYRE: Again, Mr. Commissioner, I am sorry to be bothering again, I think it is only fair if this witness is going to be asked to disagree or agree with another witness that the actual evidence of the other witness should be put to her.

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THE COMMISSIONER: Well, yes.

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MR. HUNT: I think I am in less trouble on this one because I have it.

THE COMMISSIONER: I certainly agree with what you say, Miss McIntyre, if there is any question as to the propriety of the manner in which it is formed. Sometimes we will find that we won't know how to deal with it, but we get out of it into some other kind of case where we may not have a daily transcript. It is just remotely possible, so people will have to rely on their memory. However, you have got the transcript?

18

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MR. HUNT: Yes, sir.

THE COMMISSIONER: What is the reference?

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21

22

MR. HUNT: It is Volume 85, page 8481.

THE COMMISSIONER: And is that available for the witness?

23

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MR. HUNT: It is about as brief as







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the passage I read yesterday. It turned out to be long.

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MS. MCINTYRE: What page is that,

4

please?

5

MR. HUNT: 8481.

6

THE COMMISSIONER: You are going to  
have to read it anyway because I haven't got it.

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MR. HUNT: I think my questions may  
have been somewhat clearer. In any event, I am

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looking at line 11:

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"Q. And the third piece of

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information that you gave to the

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police at that time was that after

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thinking about it, that is after

14

thinking about the fact that you just

15

didn't think you could accept all of

16

the deaths were from natural causes,

17

after thinking about it, you have

18

trouble accepting that it, that is

19

the deaths, the cause of death was

other than nursing care."

20

"A. That is what is stated."

21

"Q. That is what you told them?"

22

"A. Yes. I told them that it was

23

other than nursing. I didn't say

24

nursing care."

25







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"Q. Okay. I'm not trying to lead you to make an issue of the care or the adequacy of the care."

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"THE COMMISSIONER: Would you have difficulty believing it was other than nursing?"

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"THE WITNESS: Yes, yes."

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"THE COMMISSIONER: You had difficulty in believing what, that the cause of death was other than nursing?"

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"THE WITNESS: If indeed dig. levels were high and someone had purposely done something."

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I think that is sufficient for the point I want to make.

14

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Carol Browne indicated to us that she told the police, after thinking about it and considering the possibility that these deaths were the result of high digoxin levels administered by someone intentionally, that she had difficulty accepting that it could be someone other than someone connected with nursing.

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My question to you is, having gone through your own retrospective analysis of the situation prior to March 24th and having regard to the fact

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1  
2 that your first conclusion with respect to speculation  
3 was that it was a nurse, do you agree with Carole  
4 Browne's comment: or do you disagree with it?

5 A. How many deaths are we  
6 talking about?

7 Q. Well, I suppose it will  
8 depend on the hypothetical. I mean, assuming that  
9 the Commissioner finds that, let's leave it at the  
10 number of the deaths that we are investigating here  
11 were the result of a deliberate administration of  
12 digoxin, then my question would be, would you have  
13 difficulty accepting that it was someone other than  
14 someone connected with nursing?

15 A. I am having a bit of trouble  
16 with your question in that if it was a great number  
17 then I would have to -- if I look at it collectively --

18 Q. Yes.

19 A. -- I would agree but if it  
20 was a lesser number, then anybody could have done it.

21 Q. Sure. If it was one, it  
22 could be explained on the basis of any one of a  
23 number of people. If we get into significant numbers,  
24 then you would have difficulty accepting someone other  
25 than a nurse?

A. If we were talking about a







1  
2 high number.

3 Q. Yes, fine. I appreciate it  
4 is difficult to put a figure on it.

5 A. Yes.

6 Q. But I think I get the meaning  
7 of what you are saying.

8 Is it fair to say that during this  
9 period of time that we are looking at here, from the  
10 end of June through until March, that at some point  
11 a feeling developed in you that there was something  
12 wrong, inasmuch as there was this increase in the  
13 number of deaths but that you just couldn't put a  
14 finger on it?

15 A. I knew there was something  
16 wrong, but you are right, I could not put a finger on  
17 it.

18 Q. And it wasn't until, as you  
19 have explained, later into March of 1981 that the  
20 thought crossed your mind that some thing, and I  
21 think you said it might be reduced to somebody,  
22 although you didn't have a conscious thought of that  
23 at the time; that some thing was causing these  
24 deaths?

25 A. Yes.

Q. And I take it, and I suggest





1  
2 to you that if at some point earlier than that you  
3 had concluded that in your/<sup>own</sup>mind it was somebody who  
4 was intentionally doing this, you would have brought  
5 that to the attention of somebody?

6 A. If I had those thoughts, yes.

7 Q. And I am going to suggest to  
8 you that there is a number of reasons why the thought  
9 did not cross your mind until late into March that it  
10 was some thing or perhaps a little later some body  
11 that might be involved in these. The first of those  
12 reasons is that for you as a person dedicated to  
13 care of individuals, trained in nursing, the thought  
14 that somebody would intentionally be harming any of  
15 these children would be one that is most repugnant  
16 to you?

17 A. I would agree with that.

18 Q. Really it is a thought that  
19 is the last explanation for something of this nature  
20 that you would expect?

21 A. It would not be something  
22 that I would expect.

23 Q. Would it be fair to say as  
24 well that that response, the one that you have just  
25 given, would be a view that people connected with  
health care generally would hold and that is, as







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cr.ex. (Hunt)

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doctors and nurses, you just don't expect that someone  
connected with health care is going to be involved in  
that kind of activity?

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A. Yes.

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Q. All right. And I suppose secondly an infant cardiac ward in a children's hospital is a place where severe illness is common; would you agree with that?

A. The children are quite sick, yes.

Q. And that death - I'm not suggesting death is common but it is not unusual.

A. I cannot state the statistics because I don't know.

Q. No, no, I am not suggesting that there is any kind of statistical significance to that statement, but as a nurse you are trained to deal with death?

A. Yes.

Q. You are trained to deal with sick and dying patients?

A. Yes.

Q. And when a death occurs it is not something that may bring grief and have other trauma as far as the nurses are concerned but it is not something in a hospital where there are severely sick children it could be said to be unusual?

A. No, that's right.

Q. All right. Now, if you accept







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3 for a moment that someone, for whatever reason, I  
4 am just asking you to accept it, I am not suggesting  
5 that you have said this, but if you accept that some-  
6 one is inclined to intentionally harm a child on a  
7 cardiac ward in a hospital such as the Sick Children's  
8 Hospital and has access to the patients, then it is  
9 really virtually impossible for the hospital, the  
doctors and the nurses to prevent that from happening.

10 A. If you accept the fact that  
11 somebody...?

12 Q. Is inclined to do it for what-  
13 ever reason and they have access to the patients,  
14 I am suggesting to you that it is really impossible  
15 for the doctors and the nurses and the hospital to  
prevent that from happening?

16 A. It would be very difficult.

17 Q. All right.

18 THE COMMISSIONER: I'm sorry, what  
19 did you say to that?

20 THE WITNESS: I said it would be  
21 very difficult.

22 MR. HUNT: Q. And obviously you  
23 can't turn a hospital or a cardiac ward into an  
24 armed camp to prevent this sort of thing if it is  
25 bound to happen. I mean, it would make functioning





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2  
3 there extremely difficult if not impossible if those  
4 sorts of steps were taken.

5 A. I don't really think I under-  
6 stand what you are saying.

7 Q. Well, you have agreed with me  
8 that it would be very difficult to prevent it from  
9 happening if somebody was inclined to do it and they  
10 had access and I am just suggesting to you that you  
11 can't turn the ward into some sort of an armed camp  
12 in order to prevent it from happening or you wouldn't  
13 be able to get your jobs done?

14 A. That's right, it couldn't  
15 function in those terms.

16 Q. So, what I am suggesting to  
17 you is that somebody is inclined to do this sort of  
18 thing, for whatever reason, then a cardiac ward,  
19 an infant cardiac ward in a hospital is really a  
20 perfect forum for them to operate in?

21 A. It would depend on who the  
22 person was.

23 Q. I am suggesting again if some-  
24 one who had access to the patients was inclined to  
25 do this an infant cardiac ward in a children's  
hospital would really be a perfect forum in which  
to carry out their intentions?







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A. That makes sense.

THE COMMISSIONER: I missed that again.

THE WITNESS: I said that makes sense.

MR. HUNT: Q. So, what I suppose I am suggesting really is that it is the setting, and by that I mean the ward and the type of patients on the ward, infants, very sick, that makes it virtually impossible to protect against somebody who is inclined to harm patients?

A. It would be very difficult.

Q. And that's right, you have said that. But I am suggesting it is really the setting into which that person is going to operate that makes it virtually impossible?

A. I agree.

Q. All right. So, the key to someone's ability to carry through on their intentions, whatever the reason for them wanting to do it is, is that they have access to patients in that sort of setting?

A. I would agree.

MR. HUNT: Those are all the questions I have.





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3 THE COMMISSIONER: Yes, thank you,  
4 Mr. Hunt.

5 I guess Mr. Percival, are you next?

6 MR. PERCIVAL: Thank you,  
7 Mr. Commissioner.

8 THE COMMISSIONER: I will adopt that  
9 order unless I hear complaints. And then it follows  
10 by Mr. Olah and Miss Chown, is that what we are going  
11 to do?

12 MR. OLAH: Yes.

13 MR. PERCIVAL: Thank you.

14 CROSS-EXAMINATION BY MR. PERCIVAL:

15 Q. Miss Coulson, my name is  
16 Percival, I appear on behalf of the Metropolitan  
17 Toronto Police Force. I want to direct your mind  
18 if I might to the evening of March 21st/22nd, which  
19 is when you came on shift and had talked to  
20 Mrs. Johnstone, Lynn Johnstone, about the digoxin  
21 having been locked up. This is the beginning of  
22 the shift at about 11 o'clock to 12 o'clock, the  
23 night before Justin Cook died.

24 A. Are you referring to the  
25 Saturday night?

Q. Saturday night, yes.

A. Okay.







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3 Q. And you used the expression  
4 and have used the expression at 4145 that when you  
5 received certain information from Mrs. Johnstone  
6 about the digoxin being locked up that everything  
7 seemed "hush hush" and I would like to ask you some  
8 questions about what you meant by that because I  
9 notice that you used it again at 4265 when you  
10 talked in terms of a latter occasion some time on  
11 the Monday or Tuesday when you heard information  
12 from Mrs. Richardson. Do you remember using the  
13 expression?

12 A. "Hush hush"?

13 Q. Yes.

14 A. Certainly.

15 Q. All right. Now, what did you  
16 mean by it? Did you mean that you weren't supposed  
17 to discuss it with anyone else?

18 A. Yes.

19 Q. All right. Did it mean as far  
20 as you were concerned that you were not to advise  
21 other nurses in the Hospital?

22 A. That would have been  
23 inappropriate.

24 Q. All right. Did you feel as a  
25 result of receiving that information from





1  
2 Mrs. Johnstone about the digoxin that you had to be  
3 a little bit more alert as to your supervisory roles  
4 in the Hospital?

5 A. Alert?

6 Q. Alert as to what was going on.  
7 In other words, "hush hush" means to keep quiet  
8 about it but does it mean that you are supposed to  
9 do anything more than keep quiet about it? I want  
10 to know what you perceive to be your role after  
11 receiving that information and told to keep it quiet.

12 THE COMMISSIONER: Yes, Miss McIntyre.

13 MS. McINTYRE: Yes, is Mr. Percival  
14 asking her with respect to what she meant specifically  
15 by the words "hush hush" or what her feelings were  
16 with respect to her role, I'm not sure of the  
17 question.

18 THE COMMISSIONER: He's asking  
19 both I would have thought.

20 MS. McINTYRE: Well, it seems to me  
21 it is an unfair question because it is really two  
22 questions rolled into one.

23 THE COMMISSIONER: No, no. What did  
24 you mean by "hush hush" and by that he is getting at  
25 what did she think, what was her attitude to be  
with respect to the information being conveyed to her.







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Have I misstated it?

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MR. PERCIVAL: That's correct.

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MR. McINTYRE: As long as the  
witness understands there is really two questions.

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THE COMMISSIONER: Well, really it  
is a big question but I don't think it is necessarily  
two questions. By this time you have naturally  
forgotten the question.

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THE WITNESS: Yes, I have, I was  
going to ask you to repeat it.

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MR. PERCIVAL: Q. Well, what I  
want to know is this. You were given certain  
information first of all by, and let's deal with  
March 21st and 22nd, by Mrs. Johnstone as a result  
presumably of having received that memorandum about  
the unusual things having to be done with the digoxin.

17

A. We are talking about the  
digoxin being locked up?

18

Q. Yes.

19

A. Yes.

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Q. And you on 4145 in your  
evidence on Monday said that everything seemed to be  
"hush hush", and I want to know, did Mrs. Johnstone  
say to you don't talk to any of the other nurses?

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A. Can I tell you what I remember?

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Q. Yes, please.

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A. Okay. I remember coming on

duty and Mrs. Ross, who was the evening supervisor, took Mrs. Johnstone into another room for a private conversation. What I remember then is Mrs. Ross coming out and Mrs. Richardson, the relief supervisor, and Mrs. Johnstone and I were all in a room, so, there were the four of us.

Q. First of all, was the fact that Mrs. Ross took Mrs. Johnstone into a room and closed the door something that was rather unusual?

A. That was unusual.

Q. All right, thank you. Carry on, please.

A. So then Mrs. Ross told us that what had happened was that there had been a meeting with Dr. Carver and that Dr. Mounstephen and Dr. Costigan had asked that the digoxin be locked up and they had gone around and taken the ampules of digoxin from the crash carts and that digoxin was locked up and the supervisors had gone around to the nursing stations to tell the nurses that.

Q. That was before you came on shift?

A. That was around 10:00, 10:30.





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Q. Thank you.

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A. And then what we were to do was just to make sure that the digoxin had been locked up.

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Q. All right. Well, again then I will carry on one thing further. Following that did you have any further discussion with Mrs. Ross being present?

9

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A. No.

11

Q. All right. And then you had a further discussion with Mrs. Johnstone?

12

A. For a few minutes, yes.

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Q. All right. Well, what I am getting at is this. What gave you the feeling that everything was to be "hush hush" or to keep things quiet as a result of the information that you had just given us?

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A. There was no written memorandum for one issued to the whole of the Hospital, the fact that digoxin was going to be reissued the next morning, both Lynn and I knew that Pacsai had had a high dig. level and that together we felt it would have been inappropriate to make an issue out of it when we didn't know what the issue was.

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25

Q. Well, what I am getting at is







1  
2 this. What did you feel that you were constrained  
3 not to do; in other words, did you feel that you,  
4 as a result of receiving that information and having  
5 looked at that memorandum, that you could not discuss  
6 it with any other nurse in the Hospital? What was  
7 it or what was said, or if anything was said, that  
8 made you feel that you shouldn't discuss it with  
9 the other nurses that night?

10 A. There was nothing definite said.  
11 We felt that it would be inappropriate to discuss it.

12 Q. All right. Well, what I am  
13 getting it is this, that you have indicated that you  
14 certainly had been mindful for some eight or nine  
15 months of the increasing baby deaths. You learned  
16 the information involving Pacsai, then this rather  
17 unusual information imparted to you that night, did  
18 you not put all that together that evening, the  
19 connections?

20 A. The connections?

21 Q. Well, the connections that maybe  
22 somebody was doing something with digoxin to the  
23 babies?

24 A. When I heard that digoxin had  
25 been locked up and I knew that Pacsai had a high dig.  
level that there must have been a connection.





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Q. All right. Well, do I take it then that having discussed that with Mrs. Johnstone that you felt that one of the explanations as to why you should be hush hush is that somebody out there might be doing something with digoxin to cause the increasing baby deaths?

A. I was concerned about the concentration of the digoxin.

Q. Well, are you saying that that was your only concern?

A. At that time.

Q. Well then, if that was your only concern, and you will forgive me, Miss Coulson, but if that was your only concern why then wouldn't you feel that you could discuss it with the nurses on 4A/4B if in fact that was your only concern?

A. I felt it would, as again I said before, that it would be inappropriate. It also would have created, I would think, some hysteria.

Q. Well, you're saying that the reason behind it was that you thought that the suggestion at least you took from it all was that the digoxin that had been supplied to the various departments in the Hospital, the various wards were either of the wrong strength, I gather, or there was







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something wrong with the digoxin?

A . I was concerned that there was something wrong with the digoxin.

Q. Well, what I'm getting at is this. Why wouldn't you, if that was your state of mind, why wouldn't you then feel that it was your obligation to make sure that the nurses knew why the digoxin was being locked up and because the lab was doing tests and maybe this was the cause of the increasing baby deaths. It doesn't follow if that was your state of mind, you will forgive me for saying that.

A. That was not my responsibility.

Q. All right.

A. I cannot make that kind of a decision.

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Q Well then, do I take it from all of which you have said is that the information given to you by Miss Ross and Mrs. Johnstone is that you didn't feel you had any enhanced or increased role to play involving your supervision to prevent further baby deaths?

A Will you say that again?

Q Well, to be more alert; to see what was happening on the ward. To see if anything unusual was happening on the ward as a result of receiving that information? You didn't feel that was something you had to be concerned about the night Justin Cook died?

A I am still not sure ...

Q Maybe I am not making myself clear.

A I am just not clear.

Q Well, you have told us the reason why you felt it was inappropriate to discuss it with nurses?

A Yes.

Q And you have said that your only thought at that point was that there must have been something wrong with the digoxin?

A I was concerned with the concentration, yes.





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Q All right. Do I take it then for that reason that you didn't feel or place any connection between the digoxin and the increasing baby deaths and therefore you felt it didn't require anything more for you to do that night other than your normal supervisory roles?

A Anything more?

Q Anything more aside from going around the Hospital and being present when arrests take place?

A I was going around; I had to check and to make sure that digoxin was locked up --

Q I understand that.

A -- and thinking back, I am sure I was a little more keen on my observations.

Q All right. That is what I mean. That is what I meant by "alert", and I perhaps did not express myself too well.

In other words, I gather this made you want to be more observant to see if anything unusual was happening after you received that information from Mrs. Ross and Mrs. Johnstone?

A I will agree with that.

Q Thank you. And when that arrest took place then, and I think you were up on the 9th







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floor or the 5th floor, I'm not sure which, of Justin Cook, I suppose you said to yourself, "Oh, not another one"?

A. Not exactly. Mrs. Johnstone called me before the child had arrested. She phoned and called - I was up on the 5th floor - and she said "I need your help".

Q. And you said "That child", and that was because you and she discussed the tour end reports I gather?

A. I knew there was a sick child on 4A.

Q. Right. But in any event when the arrest did take place, and I gather did the arrest take place in your presence?

A. Yes.

Q. At that point did you think to yourself "Oh, no, not another one"?

A. I am sure it crossed my mind.

Q. All right. Well, having all of what we have just talked about, and having another arrest taking place, and I gather by that time it is about 10 in two weeks, did you feel that you wanted to be particularly more alert and more observant as to what was going on at the time of the arrest? And





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who was present? And what they did?

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A. I can't say I had that thought.

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I can't remember.

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Q. In any event I think we have

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heard evidence from Lynn Johnstone both and from you,

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that some time after the arrest occurred and when the

8

resuscitation attempt was going on, she left you with

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the nurses involved in the arrest and resuscitation

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and went back to the nursing office I gather that you

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have on the 4th floor to do other things?

A. She had her responsibilities, yes.

12

Q. And did you remain until the baby

13

died at 4:56?

A. Yes, I did.

14

Q. And you have already told Mr.

15

Lamek in fairness you do not recall ever seeing any

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of the doctors at that arrest take any blood from the

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baby after he had died?

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A. No.

19

Q. All right. At some point later

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in time were you later advised of that?

A. That's one - I don't remember

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that.

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Q. All right.

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A. I don't remember hearing anything

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about the baby having blood taken.

Q. Now you at 4156 and 4157 in the evidence of Monday described in some detail as to the attitude of Susan Nelles after the death of Justin Cook, and I think Mr. Lamek started to get into it, about the attitude or the impressions that you had of Phyllis Trayner who was I think you said out having a cigarette with Bertha Bell at the nursing station after you came out of 418.

Do you remember giving that evidence?

A. Yes.

Q. All right.

Well, can you tell the Commissioner if you can recall what impressions you had of Phyllis Trayner at that time right after the death of Justin Cook?

A. Phyllis was upset and crying, and went out to the nursing station to have a cigarette and coffee.

Q. Right. And did that crying continue for some length of time in the presence of Bertha Bell and yourself?

A. Not in my presence.

Q. All right. Can you give me anything more, any more information or any more







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impressions that you might have had in the early morning hours after the death of Justin Cook?

A. In what - as far as Phyllis was concerned?

Q. Phyllis, yes.

A. I remember after I had gone down and picked up the tray for the crash cart and had talked to Susan, I went up to see how Bertha and Phyllis were doing and they seemed fine.

Q. All right.

A. They were still having coffee. Nothing stands out in my mind.

Q. Now did Lynn Johnstone ever tell you about meeting Phyllis Trayner in the hall after the death of Justin Cook, and her views that Phyllis Trayner seemed agitated or concerned about some significant blood had been taken from the baby after his death?

A. I don't remember that, no.

Q. All right. Thank you.

Now I think you told both Mr. Lamek and Miss Forster that your first awareness of the police being in the Hospital was some time early Monday morning, March 23rd or early Tuesday morning, March 24th, and you were told by Mrs. Richardson?





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A. By Muriel Richardson.

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Q. Yes. Thank you.

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I want you to be precise if you can.

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Were you told by Mrs. Richardson that these were  
coroner's investigators or that they were Homicide  
officers?

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A. She said to me "I know Homicide  
has been called in".

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Q. All right. Had you, Miss Coulson,  
ever been involved in the situation where quote  
Homicide has been called in in any hospital prior to  
that?

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A. No.

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Q. Had you had any personal experience  
with Homicide officers prior to this event?

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A. No.

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Q. When that was communicated to you

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by Mrs. Richardson, again at 4265 yesterday morning  
you again used the same expression "hush-hush", and

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again I want you to tell me and tell the Commissioner  
if you would what you perceived to be your role after  
having received that information that Homicide had  
been called in?

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A. When I was told that Homicide

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had been called in, I was told that they didn't want

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people to know that they were in the Hospital.

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Q. All right.

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A. So I took that to mean not to

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say anything.

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Q. All right. But if someone else

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said some things to you you would communicate because

8

you would not be transgressing on what you perceived

9

your role to be? Like, for instance, Mrs. Johnstone

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at some point in time, did you talk to her that

evening of March 24th and tell her that Homicide was in?

11

A. That was the Tuesday evening?

12

Q. Yes.

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A. Yes.

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Q. All right. I gather you felt

you could impart that information to her?

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A. She was the only person I told, yes.

16

Q. All right. Did you gain the

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impression that particular evening or the next morning

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that there were a number of other people within the

19

Hospital had that similar information?

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A. I had no idea.

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Q. So far as you were aware then

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do I take it that it was the senior supervising nurses

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that had the information and you did not make

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inquiries as to whether anybody else did?

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A. The only people that I knew that knew that Homicide were called in were Muriel who told me that Miss Geiger knew and that I told Lynn, so to my knowledge there were four nurses that knew.

Q. All right. No one else said anything to you in the course of that shift, any of the other nurses on the wards that you can recall?

A. Oh, no.

Q. Now, may I talk about the discussion that you had on the evening of Tuesday, March 24th with Lynn Johnstone, and you have given evidence on the last two days of this discussion that you had in the hallway with Lynn Johnstone. And I wanted to be precise.

You say it was in the corridor. Was it shortly after you came on shift at 11 o'clock that night that you had the discussion?

A. It was after we had had reports; just before we went to make our rounds.

Q. So what time would that be approximately?

A. Oh, quarter to one.

Q. All right.

A. Twelve-thirty, quarter to one.

Q. Thank you.





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A. Before 1 o'clock.

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A. That is correct.

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Q. And your recollection is that having received that information from Mrs. Richardson you thought certain things but didn't express them, and the first time you expressed anything to anybody was Mrs. Johnstone?

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Q. Right. It is your recollection as I understand your evidence that both you and Lynn Johnstone speculated about Homicide being in the Hospital and what that meant?

A. I remember saying to her "Homicide, does that mean murder?".

Q. And I gather that both of you said two names. Who said the name first?

A. I did.

Q. All right. Mrs. Johnstone's reply was Susan Nelles?

A. Yes.

Q. All right. And I think you said yesterday that as a result of that it seemed like a draw. I think I use your expression. Is that right?

What I want to know is this: as to why those two names came to mind more so than any of the other members of the Trayner team or any of





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the other people that would be present for many of these baby deaths, and for instance why was it more likely that you would use the name Trayner than, say, Sui Scott or Janet Brownless or Christie or even Bertha Bell who we know was not of the Trayner team but was always on 4B which is in effect the same geographical area of the Hospital?

Why was it that you singled out at least in your mind Phyllis Trayner?

A. It seemed to me that Phyllis was always there, and I can - I have given my reasons in evidence. There was another reason and that was when she came back from her honeymoon, the first night she was on there was an arrest, and there hadn't been before that, and that seemed to just click, and that is why I said Phyllis.

Q. When you said it clicked, did it click back then in 1980 or did it all of a sudden come to your mind that - or come to an expression to Lynn Johnstone something that you had been thinking about for nine months?

A. I knew that Phyllis had been on for a lot and Susan had been on for a lot. I had been on for a lot.

Q. But in fairness to you,







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Miss Coulson, you were there on the arrests because  
you were asked to be there?

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A. I respond to the Codes, yes.

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Q. Yes, I understand.

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MR. BROWN: Well, in fairness to the  
other nurses, they are there because they are assigned  
to care for those babies.

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THE COMMISSIONER: Yes. I agree with  
everything everybody has said so far.

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MS. MCINTYRE: But I don't --

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MR. PERCIVAL: You know I have always  
been criticized for being critical of the witness. I  
was trying to end up making it clear.

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MS. MCINTYRE: But I think what  
Mr. Percival did was to interrupt her in the middle  
of an answer.

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MR. PERCIVAL: I thought --

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MR. LAMEK: Are you doing that again?

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MR. PERCIVAL: I think it is beware  
of people bearing gifts or something like that.

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Q. Miss Coulson, would you respond  
to the question, uninterrupted.

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MR. LAMEK: What was the question?

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THE WITNESS: What was the question?

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MR. PERCIVAL: Q. Why was it - you





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have indicated we talked in terms that she was there for them, Susan Nelles was there for some of them, one thing that you thought at that point was that there hadn't been some baby deaths for a number of weeks if not months, and correspondingly Phyllis Trayner had been on her honeymoon, and the very night she came back from her honeymoon on the first shift another baby arrested and died.

A. That is right.

Q. All right. Any other reason?

A. No.

Q. Do I take it then when Lynn Johnstone said Susan Nelles, it was also - you had to concede at least in your own mind that she was there for very many of the baby deaths?

A. Yes, that is correct.

Q. And in fairness to you there had been at least according to the facts and figures in this Commission - we are talking in terms of a minimum of 36 baby deaths that had occurred up until that time or 35 up until just before - in fact 36 at that point in time?

A. Yes.

Q. All right. Now do I take it that all of those 36 deaths weren't in your mind, the





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details of them?

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A. There were no details. I was

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thinking collectively --

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Q. I see.

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A. -- back to the events from July.

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Q. Well, when you and Lynn

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Johnstone had this interchange and you said one and she said the other, quite apart from saying it seemed like a draw, did you consider that a very distinct possibility because of what you have indicated; that with the increasing baby deaths with the same nursing team, that there may be more than just one person involved as a suspect so far as Homicide was concerned?

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A. We stopped our conversation because it was very frightening.

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Q. Miss Coulson, I didn't ask you that, whether you stopped your conversation. Did you consider the possibility at that point of having her come back with another name, that you might be dealing with not just one but perhaps two people that might be suspected in relation to the events that you have described?

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A. I never thought that.

19

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Q. Now, that particular night, do I take it that you knew from what Mrs. Richardson had told you that Homicide was in the Hospital, you obviously thought that they were investigating something?

23

A. Yes.

24

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Q. And did you at least in your





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2 own mind think of what they were investigating?

3 A. The baby deaths.

4 Q. Well, the one that you have  
5 indicated that you knew something had to do with the  
6 digoxin and a high digoxin level was Baby Pacsai at  
7 that point?

8 A. Yes.

9 Q. And did you or Mrs. Johnstone,  
10 or did you think in your own mind at that point,  
11 speculate which baby deaths the Homicide was likely  
investigating?

12 A. I had no idea.

13 Q. Did you even think about it?

14 A. I don't remember.

15 Q. You see, what I am getting  
16 at is, did you think it really had something to do  
17 with the ten baby deaths in the last two weeks cul-  
18 minating with the night that Justin Cook died early  
Sunday morning?

19 A. Mr. Percival, I didn't know  
20 what they were investigating.

21 Q. I think you told Mr. Hunt  
22 yesterday, and you were cross-examined on this at  
23 page 4368, that you couldn't answer for Mrs. Johnstone;  
24 and when you were asked, wasn't it surprising that  
25





Coulson  
cr.ex. (Percival)

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Mrs. Johnstone doesn't seem to recall that conversation --

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do you remember being asked that?

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A. Yes, I do.

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Q. And giving some answers?

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A. Yes.

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MS. McINTYRE: She also I believe answered that she wasn't surprised. She was asked that question twice; she gave two answers.

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MR. PERCIVAL: Well, Miss Coulson, tell me what your feeling was then, if it is different or if it was contradictory yesterday, as Miss McIntyre says. Tell me, did you feel somewhat surprised to hear Mrs. Johnstone give evidence last week to the effect that she had absolutely no recollection of your meeting in the corridor and you both speculating on the baby deaths? You were here last week when Mrs. Johnstone gave evidence?

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A. Yes, I was.

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Q. And you heard her say that she had no recollection of hearing any reference to the Homicide Squad or speculating with you as to the possible suspects that evening of March 24th/25th? You heard that evidence last week?

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A. Yes.

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Q. What I am getting at is this:







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You seem to have a very precise and certain recollection of the events; did you find Mrs. Johnstone's evidence to the contrary surprising, that she couldn't recall?

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A. Yes, I was.

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Q. I will go one step further.

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Mrs. Johnstone told Miss Kately on Wednesday, February 15th, at page 3809, and I say that for the benefit of Miss McIntyre, that both you and Mrs. Johnstone discussed each other's evidence when you were being prepared by Miss Kately before Mrs. Johnstone gave evidence.

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A. Last --

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Q. Is that correct?

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A. Would you repeat that again.

16

Q. Yes. Did you, before Mrs.

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Johnstone gave evidence, meet with Miss Kately and Mrs. Johnstone and did you talk about the evidence both of you were to be giving?

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19

A. We discussed the fact that both of us had had conversations.

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Q. That is what I am getting at.

22

At that meeting, again before Mrs. Johnstone gave evidence, was your recollection about this corridor meeting with Lynn Johnstone and the speculation and

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Mrs. Johnstone's total absence of recall ~~of a matter~~ of  
discussion between you and her?

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A. We discussed --

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Q. I am not talking about you  
and your counsel, because that is not something I  
can get into.

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A. Lynn and I discussed it in  
the presence of our counsel, yes.

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Q. All right. Well, at that  
point did you have a clear and precise recollection  
that Lynn Johnstone had a total absence of recollection?

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A. That is why I was surprised  
that she didn't remember.

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Q. All right. Thank you.  
Now may I deal with the question of  
the time that Susan Nelles I understood was charged  
with one, the murder of Justin Cook on March 25th,  
and you became aware of it very quickly.

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A. I heard it on the radio, yes.  
Q. And did you also hear later  
in the same week, March 27th, that Susan Nelles had  
been charged with the murder of Baby Estrella, Baby  
Pacsai and Baby Miller?

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A. Yes.





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Q. So when we come to your first involvement with the police on April 3rd, you were aware that those were the four murder charges facing Susan Nelles?

A. Yes.

Q. And you certainly were present relating to Justin Cook. Did you give any thought to the other three babies now for which their deaths were being charged against Susan Nelles, Estrella, Pacsai and Miller, before you met with the police on the morning of April 3, 1981?

A. Yes.

Q. And do I take it that when you went in to see Sgt. Warr on that occasion you expected to be questioned relating to the four known murder charges and the four babies that I have already talked about? Is that fair to say?

A. Yes. Yes.

Q. And I gather the problem was that when you went in to that meeting with Sgt. Warr you were well aware of the events in some considerable detail of the nine months preceding and the mounting incidents of baby deaths, and it became evident to you very quickly that the police were not interested in all of these other babies, but of the four for which







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2 murder charges had been laid against Susan Nelles;  
3 is that correct?

4 A. That is what I found out when  
5 I talked to him.

6 Q. Thank you. And prior to  
7 talking to Sgt. Warr, did you make a point of  
8 looking at any of the Hospital charts to determine  
9 who was and who was not present with respect to the  
10 deaths of Estrella, Pacsai and Miller?

11 A. No, I did not.

12 Q. So whereas you thought about  
13 it, I guess you didn't do anything more other than  
14 think about it before you met with Sgt. Warr on  
15 April 3rd?

16 A. That's right.

17 Q. And I was intrigued by your  
18 comment, I think it was on Monday if not on Tuesday,  
19 that your evidence was, at page 4180, "I told them  
20 I had trouble believing that Susan did it and that she  
21 had not been there for some of the deaths". I think  
22 I have paraphrased that correctly. Do you remember  
23 saying that?

24 A. Something to that effect.

25 Q. And in fairness, when Mr.  
Hunt, and I think another counsel, questioned you on





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that, you had difficulty remembering your exact words.

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Again, is that fair?

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A. That's fair.

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Q. Now you were obviously thinking

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of the nine months past when you expressed those  
words I gather?

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A. Yes.

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Q. And did you really think at

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that point in time that whether it was 20, 25 or 36 baby

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deaths, that is something that the police should be

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looking at and thinking of charging an individual?

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A. Would you say that again,

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please.

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Q. You see, you talk in terms

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of deaths generally.

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A. Yes.

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Q. And we know that there were

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at least 36 on that ward.

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A. Yes.

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Q. And when you said that, that

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she had not been there for some of the deaths, do I

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take it that at least in your mind the police should

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have been looking at 36 possible homicides at that

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particular point?

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A. I would say I had trouble with





D9 1 the fact that Susan could have been the guilty person.

3 Q. I understand your comment.

4 THE COMMISSIONER: I don't think she  
5 was finished.

6 MR. PERCIVAL: I'm sorry.

7 Q. Carry on please. Go ahead.

8 A. Okay. So that is what I  
9 was saying, I had trouble with that, the fact that  
10 she wasn't there for some of the deaths, and I was  
again talking collectively.

11 Q. I understand.

12 A. I cannot say what I thought  
13 the police should be investigating; I was looking at  
it collectively.

14 Q. What I am getting at is this,  
15 though: Do I take it that babies sometimes die in the  
16 hospital for other than non-deliberate or non-negligent  
17 reasons?

18 A. That's right.

19 THE COMMISSIONER: There are a lot  
20 of negatives in that and I am not sure you got the  
answer that you really wanted.

21 MR. PERCIVAL: Well I have always  
22 expressed the idea, Mr. Commissioner, that I am never  
23 particularly articulate in cross-examination.

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THE COMMISSIONER: That is not the  
general view.

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MR. PERCIVAL: Q. Perhaps, Miss  
Coulson, I will put it again.

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Do I take it though that it has been  
your experience in hospitals, particularly in children's  
hospitals up until 1981, that children do die in the  
hospital for, if I can use the expression, natural  
reasons as a result of their illness?

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A. Yes.

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Q. What I am getting at is this:  
You were thinking of nine months of baby deaths and  
it looks like about 36. I gather you must have been  
mindful of the fact that maybe some of those babies  
died as a result of natural means?

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A. I was looking collectively  
at nine months of baby deaths that happened during  
the night, that happened at a specific time.

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Q. In any event, I gather before  
you came to this Commission on Monday morning, you  
were provided with the statements that you had given  
to the police, or a resume of the statements you had  
given to the police on four separate occasions?

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A. April 3rd, April 29th, this  
is the --





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Q. There were two others, on  
September 22, 1982 and December 8, 1982.

A. That's right.

Q. I wanted to be sure that you  
have those. Now, you have expressed on a number of  
occasions that you had certain distinct suspicions  
about Phyllis Trayner and of the innocence of Susan  
Nelles; is that fair to say that even on the night  
of the 24th you had that view?

THE COMMISSIONER: There is something  
wrong with that sentence. You had suspicions of the  
innocence...

MR. PERCIVAL: All right. Perhaps  
I will put it again.

THE COMMISSIONER: Yes.

MR. PERCIVAL: Q. You had suspicions  
of the culpability of Phyllis Trayner and views with  
respect to the innocence of Susan Nelles?

THE COMMISSIONER: I think if I can  
put it.

MR. PERCIVAL: By all means.

THE COMMISSIONER: You had some  
views, did you not, involving these deaths that it  
was Phyllis Trayner and it was not Susan Nelles because  
Susan Nelles could not have been there when some of





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the deaths of the children occurred; is that right?

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THE WITNESS: That's right.

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THE COMMISSIONER: Now...

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MR. PERCIVAL: Thank you.

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Q. And I think that Mr. Hunt has asked you whether - and I think Miss McIntyre put the statement in - whether you agreed there is no reference on April 3, 1981 of that expression of your opinion or belief?

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A. There is no record of it.

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Q. And in fact I ask you to consider any of the four documents that you have been provided with; is there any such expression by you in any of those documents as to the culpability of Trayner and the innocence of Nelles?

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A. I would like to look over them.

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Q. All right. Would you like to take a moment now?

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A. Yes.

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THE COMMISSIONER: I take it these latter two are not before us yet; is that right?

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MR. PERCIVAL: That's correct. I don't even think the second one is.

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MR. LAMEK: The second one is not.







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THE COMMISSIONER: The second one is  
not?

MR. PERCIVAL: No. That is the one  
involving the questions about Miller.

MR. ROLAND: While the witness is  
looking, my only concern, and it is one that I  
expressed some time ago and I think Mr. Percival has  
agreed to it, as I understand it, some of these  
documents are after the end of the preliminary and  
they are of no significance to this Inquiry.





/BM/ak

1  
2 THE COMMISSIONER: Well, certainly,  
3 they are of no relevance to the police aspect but  
4 as to the - well, the fact that they know they were  
5 taken has nothing but it may, it may by looking at some  
6 statement that is later taken on it, it may be of some  
7 assistance to us and one of the first to - I don't  
8 know whether it will or whether it won't. I take it  
9 what Mr. Percival is seeking to establish is that  
10 even after, she never said at any time afterwards  
11 and from that one could infer perhaps that she didn't  
12 say it before, I don't know.

13 MR. ROLAND: Well, I'm just mindful,  
14 sir, to try and contain the ambit of this Inquiry  
15 and if we are going to get into it for all sorts of  
16 reasons beyond the Inquiry, the preliminary inquiry  
17 stage we will be here a long time.

18 THE COMMISSIONER: I agree, I agree  
19 with that.

20 MR. PERCIVAL: Q. Miss Coulson, can  
21 you answer the question?

22 A. Would you repeat it.

23 Q. I want to know whether or  
24 not in any of those statements that you gave to the  
25 police on the occasions in question is there any  
reference whatsoever to the fact that for instance





1  
2 Nelles was not present at some of the deaths?

3 A. No, it didn't.

4 Q. All right. And is there any-  
5 thing in the statements that indicate  
6 your expression or opinion or belief that Phyllis  
7 Trayner was the more culpable individual between  
8 she and Susan Nelles?

9 A. There is nothing written down.

10 Q. Thank you.

11 MS. McINTYRE: Mr. Commissioner,  
12 I am familiar with these statements and I think there  
13 is a matter of argument on that.

14 MR. PERCIVAL: She's got another  
15 chance.

16 THE COMMISSIONER: But you get a  
17 chance to re-examine on this very issue.

18 MS. McINTYRE: Fair enough. But  
19 I have real concern about putting these statements  
20 in or even getting into them, although, I agreed  
21 on the first one.

22 THE COMMISSIONER: Well, the less  
23 that is said about them the less chance there is  
24 of them getting in, I would think. But this is a  
25 problem. Do you want to put them in now?

MS. McINTYRE: No, I don't,







1  
2 Mr. Commissioner.

3 THE COMMISSIONER: All right.

4 MR. PERCIVAL: Q. Now, would you  
5 agree with me also that in these four statements  
6 there is no reference to the death of Baby Lombardo  
7 and your meeting with David Nelles on, I gather,  
8 the night of the 23rd or 24th of 1980?

9 A. There is nothing written down.

10 Q. And I suggest to you, Miss  
11 Coulson, that at no time did you ever tell any police  
12 officer, quite apart from any Crown Attorney, about  
13 this discussion that you had with Dr. David Nelles  
involving the death of Baby Lombardo?

14 A. I don't remember.

15 Q. You don't remember. May I  
16 take you to one further area, and I think Mr. Hunt  
17 started into it yesterday, this is at 4392 and 4394  
18 as to your impressions as to Phyllis Trayner at the  
19 time an arrest was called and the baby was attempting  
to be resuscitated.

20 A. Which baby?

21 Q. Any baby?

22 A. Any baby.

23 Q. All right.

24 A. Okay.  
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3 Q. And I think you conceded that  
4 Phyllis Trayner -- Does the witness want some time  
5 to look at this, I don't know why it is being done.

6 MS. McINTYRE: Well, you referred  
7 to it, I thought I would provide her with it.

8 THE COMMISSIONER: All right. Well,  
9 I missed that but at any rate there was a question.

10 MR. PERCIVAL: Q. Do you have  
11 difficulty recalling what you said yesterday to  
12 Mr. Hunt about this?

13 MS. McINTYRE: Mr. Commissioner,  
14 previous witnesses have had transcripts put before  
15 them if reference has been to their previous  
16 testimony.

17 THE COMMISSIONER: Well, it's not  
18 an invariable rule but if the witness has trouble,  
19 by all means. But if the witness knows perfectly  
20 well what she said it's not unreasonable to say --  
21 you see, you can't expect everybody to give the  
22 transcript at all times. Now, if you think, if you  
23 legitimately think there is some real problem,  
24 as there is sometimes when you are reading two or  
25 three pages of transcript, by all means let's have  
it but I don't want to hold it up every time because  
that isn't the way we cross-examine and it detracts





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3 a little from cross-examination.

4 However, I'm not making a ruling on  
5 that. You now have your thing on this case, have  
6 you?

7 THE WITNESS: Yes.

8 THE COMMISSIONER: And I have forgotten  
9 what the subject matter is.

10 MR. PERCIVAL: Q. Miss Coulson,  
11 in any event, you said that at the time that Phyllis  
12 Trayner was involved in the arrest procedures  
13 involving any baby that she was very vocal and that  
14 she liked to take over and that she liked to direct  
15 people. Is that all of that correct?

16 THE COMMISSIONER: It's not really  
17 a question of whether you said it, it really is a  
18 question of whether it is correct or not. Would you  
19 like to see it again and if you want to make any  
20 changes to what you said or if you want to clarify  
21 it in any way you can do it.

22 THE WITNESS: She was vocal but not  
23 all the time, not at every arrest but often she was  
24 vocal.

25 MR. PERCIVAL: Q. Well, I think you  
agreed with Mr. Hunt's proposal that she seemed to  
be somewhat aggressive during the arrest procedures?







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A. Yes, at times.

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Q. All right. In fact, as a result of that aggressiveness during arrest procedures, did you ever ask her on a number of occasions to change her activities during arrests procedures?

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A. I suggested that she settle down a bit.

9

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Q. All right. And did you have to do that on a number of occasions as opposed to just one occasion?

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A. Two or three times.

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14

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Q. Thank you. And that aggressiveness that occurred during the arrest procedures, once the death occurred was there some distinct change in Phyllis Trayner?

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A. Phyllis would always go through - no, Phyllis always went out for a cigarette and she was usually crying.

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Q. All right, and would she shake visibly?

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A. Sometimes I would see her shaking.

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Q. Yes. I gather that if she would cry and shake and go for a cigarette would she ever, that you can recall, ever assist in the





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cleanup of the baby or the room following an arrest?

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A. She may come in after she's  
had her cigarette.

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Q. I know, but by that time I  
gather the work has been done.

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A. My vivid recollection of  
Phyllis was going and having a cigarette. I can't  
say whether she cleaned up or whether she didn't.

10

Q. All right.

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A. To my recollection she didn't.

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Q. Well, Mr. Hunt alluded to this  
yesterday. Did you view the deaths of these babies  
when Phyllis Trayner was involved in the arrest and  
the resuscitation as a bit of a release mechanism  
at least so far as Phyllis Trayner was concerned?

16

A. I can't answer that question.

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Q. All right. Miss McIntyre  
asked you yesterday at 4273, she asked you whether  
you were ever interviewed by the police about  
Estrella and Pacsai. Do you remember being asked  
that?

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A. Yesterday?

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Q. Yes, it is at 4273 if you have  
it in front of you please.

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A. Okay.

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Q. It is two questions, two answers, both of which are "No".

A. That's right.

Q. All right. You were in fact interviewed extensively by Sergeant Warr on April 3rd about Baby Cook?

A. Yes.

Q. You were interviewed at some detail by Constable Murray on April 28th involving Allana Miller?

A. Yes.

Q. You gave evidence insofar as your involvement in those baby deaths at the preliminary hearing?

A. Yes.

Q. You didn't want to leave the impression with the Commissioner that because they didn't ask you about Baby Pacsai and Baby Estrella that you viewed their investigation as less than competent. Did you want to leave that impression with those questions and those answers?

A. Did I want to leave that impression?

Q. Yes.

A. No, I didn't.







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Q. All right. Well, because in fact when you were questioned at the preliminary hearing about Baby Pacsai and Baby Estrella you had some difficulty even remembering the arrests and the deaths of those two babies, isn't that correct?

A. I have great difficulty remembering Janice Estrella, yes.

Q. And Baby Pacsai?

A. I remember going into the room before he was transferred to the unit.

Q. All right, but you have difficulty I suggest, and I gather you have reread your evidence at the preliminary hearing?

A. Yes, I have.

Q. You had difficulty involving Baby Pacsai, aside from being in there, as to who was involved, what occurred at that time of the arrest?

A. That's right.

MR. PERCIVAL: All right, thank you.

THE COMMISSIONER: Yes, Mr. Roland?

MR. LABOW: Excuse me, Mr. Commissioner, before we continue.

THE COMMISSIONER: Yes.

MR. LABOW: My understanding of your





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2 ruling regarding Carol Browne's statement and your  
3 "general rule" was that when several counsel have  
4 the statement and refer to it, it should be produced  
5 to all counsel.

6 THE COMMISSIONER: There comes a  
7 time, there comes a time. Are you suggesting that  
8 time has now come?

9 MR. LABOW: I would suggest at least  
10 with regard to the statement on April 28th or 29th  
11 that she gave to the police prior to the preliminary,  
12 enough counsel have referred to it and the witness  
13 has referred to it enough in the witness box that  
14 other counsel should at least be given the opportunity  
to see it.

15 MS. McINTYRE: I have no objection  
16 to that statement being given to other counsel or  
17 being made an exhibit. In fact, I believe Mr. Lamek's  
18 office has made copies of it. I don't know whether  
they are here right at the moment.

19 THE COMMISSIONER: You can't have any  
20 objection?

21 MR. PERCIVAL: I can't have any  
22 objection if the witness and her counsel agree to it.

23 THE COMMISSIONER: Yes, all right.  
24 Well, I take it, do you pay some attention to what  
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2 Miss McIntyre says?

3 THE WITNESS: Yes.

4 THE COMMISSIONER: Well then, your  
5 motion, you've won.

6 MR. LABOW: Thank you.

7 THE COMMISSIONER: I don't know  
8 when you win.

9 MR. LAMEK: Miss McIntyre is entirely  
10 right, sir, copies have been made but no member  
11 of my gang is with me at the moment and therefore  
12 I won't be able to get them until after lunch.

13 THE COMMISSIONER: As soon as you  
14 can press them into action, which will probably mean  
15 after lunch.

16 Yes, Mr. Roland?

17 CROSS-EXAMINATION BY MR. ROLAND:

18 Q. Miss Coulson, you told Mr. Lamek  
19 I think on two occasions that you had a conversation  
20 with Dr. Costigan concerning the baby deaths and  
21 your concern about them and you were fairly vague  
22 about when that occurred. Did you have just one  
23 conversation with him?

24 A. There was more than one but  
25 again they are very vague because they were not formal  
meetings.







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Q. Yes.

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A. We would meet in the hall and talk about it or it was after an arrest.

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Q. I take it the occasion of those conversations was when he was on duty as the resident and you would meet by chance in the hallway in the Hospital either on 4A/B ward or even some other ward?

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A. That's right.

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Q. And it was in the course of a casual conversation and you may have been talking about other things as well?

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A. That's right.

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Q. Yes. It was just something that you I gather recollect bringing up at the time or mentioning to Dr. Costigan. Or did he mention it to you?

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A. I don't know, I don't remember.

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Q. You don't remember?

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A. I don't remember who brought it up.

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Q. All right. And I gather you put at least one conversation some time around January of '81 because he indicated that something was being done about them and that that coincided with your understanding that there was consideration





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3 being given to the establishment of an intermediate  
4 ICU.

5 A. It was around that time, yes.

6 Q. Yes. And you have told us that  
7 you thought in speaking with Dr. Costigan that he  
8 was aware that there were a number of babies dying,  
9 they were dying at night, they were dying on Ward 4A/B  
10 and you said that you talked about the same nursing  
11 team as well. Are you sure that you talked to  
12 Dr. Costigan about that, about the fact that it was  
13 the same nursing team?

14 A. To the best of my recollection  
15 that's what I remember telling him.

16 Q. I see, all right. You see,  
17 Dr. Costigan has testified here last, I think October,  
18 and although that question and your conversation  
19 with him wasn't put to him, certainly I reviewed his  
20 evidence and the impression you get from his evidence  
21 is, he wasn't aware of that. But you remember telling  
22 him that, do you?

23 A. I remember it coming up in  
24 conversation, the fact of the same nurses, plus the  
25 fact that it always happened at night.

Q. I see, all right. And you  
say that what you did is, you remarked about these





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3 deaths to Dr. Costigan at least on a couple of  
4 occasions and one you can remember about January '81,  
5 and you also brought it up to a number of nurses  
6 in the nursing office and you have indicated that  
7 those nurses include Miss Sword and Mrs. Pyykkonen  
8 and Mrs. Miller and Miss Greenleaf, and there may  
9 have been others, but you brought that up you think  
10 in the summer of '80 and again in the winter of '81.

11 I take it the conversations you had  
12 with them again were casual conversations that you  
13 had speaking with them about a number of matters  
14 and you again raised this as an observation that  
15 you had made that there were these increased deaths  
16 and they were on the ward and they were at night.

17 A. That's right, there was no  
18 formal meeting with them.  
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Q. And that they heard you and they seemed to understand what you were saying? No difficulty there?

A. That is right.

Q. In accepting that? All right.

I gather what you observed apart from the increased deaths was that there were basically sort of two cluster periods of deaths. The one you told us that was in the summer in July and August, and then again in December, and those were the - I gather those sort of clusters of deaths coincided with your observations both with Dr. Costigan and with these nurses?

A. Yes.

Q. And I gather when you raised it in December or in early January of 1981 you also observed that of the deaths - in the month of December, and I think there were five, two of them were on 4B; two out of the five were on 4B rather than 4A? I think I am right on that.

A. In December?

Q. Yes. Baby Belanger died on 4B and so did Onofre?

A. I wasn't there for Belanger.

Q. I take it it was that cluster





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that you were concerned about in this conversation  
in January of '81?

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A. The cluster, yes.

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Q. That sort of cluster of five  
deaths in December, and did you observe as well when  
you had that conversation that two of those five  
deaths occurred not on 4A but on 4B, or did you make  
that distinction?

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A. I don't think I made that

distinction.

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Q. And when you were thinking about  
these deaths did you make any distinction about  
whether they were on 4A or 4B or was it all in your  
mind one ward?

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A. The majority seemed to be on 4A.

The majority was 4A.

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Q. When you say the majority was 4A,  
I take it you did make a distinction between 4A and 4B?

A. There was a distinction in that  
they were separate wards.

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Q. Yes.

A. Yes.

Q. And did you make a distinction  
in your mind as well - or would you have made a  
distinction if it had been brought to your attention





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that of the five deaths in December two of them had been on 4B, that would involve a different nursing team than the Trayner team? That is the Trayner team was a 4A team not a 4B team?

A. Yes, but in a cardiac arrest situation usually the nurses on both sides go together.

Q. I see. So when you talk about the fact that the same nurses and particularly you told us about your observation of Phyllis Trayner, were there, you are talking about at the arrest I take it?

The same, when you observed, Phyllis Trayner was there at a lot of these deaths, what you are talking about is she is there at the arrest because I gather that is when you attend. You were there at the arrest and you see her?

A. When I talk about they were there --

Q. Yes.

A. -- Phyllis' team was on.

Q. Yes.

A. For that shift.

Q. Yes.

A. And so she, yes, was there for the arrest.







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Q. Yes. And you make no distinction then between a baby on 4B and a baby on 4A in your observation that Phyllis Trayner's team was there?

A. It was still happening on her shift.

Q. Yes. All right.

You told us you did not attend the mortality and morbidity conferences that were held in September, two of them in September, and in fact I gather you weren't aware of them?

A. I wasn't aware of them.

Q. No. We know from evidence that has gone before that at those conferences there were staff cardiologists, several Fellows, and at one of them nine nurses and the other seven nurses, and those included Mrs. Radojewski and Mrs. Pyykkonen and Miss Geiger.

I take it that you have no criticism of the fact that there wasn't sufficient sort of nursing expertise and knowledge and familiarity with the situation at those meetings?

A. If those people were there then that is fine with me.

Q. That is fine with you?

A. Sure.





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Q. Because, for instance, you have already told us that you had spoken with Mrs. Pyykkonen about your observations some time in August?

A. She knew about what had been going on.

Q. Yes. And if those same people were at the meeting, the mortality and morbidity meeting that occurred in January of 1981, together with staff cardiologists and residents again I take it you have no criticism about the fact there wasn't sufficient nursing expertise and knowledge brought to bear on the problem in those meetings?

A. I would assume that there was the expertise there. If those nurses were present at the meetings, that they would have contributions, yes.

Q. In fact you have told us that Mrs. Radojewski has great experience in cardiology?

A. Oh, yes.

Q. In fact she was a nurse much closer to the situation on 4A than you were?

A. The total situation, yes.

Q. And you also told us that you learned there was going to be, you called it a step down unit. I take it that is an intermediate ICU?





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Q. And you learned that there was consideration of that when you had your conversation with Dr. Costigan in about January of 1981, and that eased your concerns.

I take it from your observation that that eased your concerns, that you were satisfied that it appeared from what you knew proper steps were being taken to try to deal with the problem of increased deaths on the ward?

A. Yes. I felt that people were looking into the baby deaths.

Q. And at that time when you heard there was consideration of an intermediate ICU, that I take it at that stage answered your concerns?

A. Yes.

Q. Now you also told us you had a conversation with Dr. Schaffer and you think that might have been in January, February or March.

I gather you really can't tell apart from a three-month span when that conversation was?

A. No, I can't. It would seem to me for me to have a conversation would be when there were - when he was present on the floor, so that would be when there would have been an arrest or a critically ill child when I was on duty.





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Q. Yes.

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A. But to be specific about dates,  
I can't tell you.

5

MR. ROLAND: Thank you. Those are  
all the questions I have.

6

7

THE COMMISSIONER: Thank you.

8

Miss Chown?

9

MS. CHOWN: No questions, thank you.

10

THE COMMISSIONER: Mr. Knazan?

CROSS-EXAMINATION BY MR. KNAZAN:

11

12

Q. Mrs. Coulson, my name is Brent  
Knazan and I represent Mrs. Christie.

13

14

When you saw Susan Nelles bathing  
Baby Cook after Baby Cook's death you say Mrs. Christie  
was in the room. Is that correct?

15

16

A. Yes, she was feeding a baby.

17

18

Q. She overheard the conversation  
at least to the point of being able to offer you a  
nicer gown or sleeper for the baby; is that right?

19

20

A. Yes.

21

22

Q. Do you think she overheard the  
rest of the conversation with regard to the baby  
coming up from Owen Sound?

23

24

25

A. She was close enough that she  
would have heard the conversation.







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Q. She would have been able to hear?

3

A. I would think so.

4

Q. But she was also attending to  
her baby in the room?

5

A. That is right.

6

Q. And it is also possible that  
she may not have heard that conversation?

7

8

A. She may not have paid any  
attention. I don't know.

9

10

Q. When you saw Susan Nelles wash  
the baby, did you see that process from beginning to end?

11

12

A. No, I didn't.

13

Q. So had she already commenced it  
when you came in?

14

15

A. She was just about finished  
bathing the baby when I entered the room.

16

17

Q. And did she finish it by the  
time you left?

18

19

A. Oh, yes. We had - Susan had  
dressed the baby and then I made the bed, so that was  
finished when I left.

20

21

Q. And you didn't see Janet  
Brownless bathing the baby at any time that night?

22

23

A. No, I didn't.

24

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Q. You also mentioned that the





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deaths seemed to be bringing the Trayner team closer together in your evidence. Do you recall that?

3

4

A. I remember saying that.

5

6

Q. Yes. Did you mean the whole Trayner team or did you have certain members of it in mind?

7

8

A. I seemed to sense a feeling of care for each other, support, that is what I meant by that.

9

10

11

Q. You sensed it? Do you have any recollection of specific instances Mrs. Christie manifesting a coming closer to other members of the team around this issue?

12

13

14

A. Mrs. Christie seemed to always go and watch the other kids, and so she would assume that responsibility. And to me that was her way of helping out and supporting the others.

15

16

17

Q. That is during an arrest?

18

A. Yes.

19

20

Q. But that would be the normal function of an RNA during an arrest on the ward, wouldn't it?

21

22

A. Yes.

23

24

25

Q. Now you stated yesterday to Miss Forster that you didn't think that her client -





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you stated to the police in 1982 you didn't think  
her client had the brains to do this; something to  
that effect?

4

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A. To orchestrate.

6

Q. Yes. Now in the Atlanta Report  
which you mentioned you have heard of.

7

8

A. Yes.

10

Q. Which is an exhibit to this  
Inquiry, 324, the authors give a portrait in a part  
they describe in evidence as speculation they give a  
portrait of a possible perpetrator if such a thing  
happened.

12

13

They state at page 28 of Exhibit 324:

14

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"The cause of the epidemic went  
unrecognized for almost nine months  
suggesting that the perpetrator had  
enough clinical knowledge to choose  
victims whose deaths would not  
initially be considered suspicious."

19

20

So that type of clinical knowledge, is that part of  
what you were considering when you made the statement  
someone didn't have the brains to do this?

21

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23

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A. I didn't take that into effect.

I was looking, when I said that, I just didn't seem  
to think that Phyllis would be able to - capable of







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organizing and killing this great number of babies.

3

Q. And pulling it off so that it

4

goes unsolved?

5

A. Yes.

6

Q. So you were recognizing that if

7

this occurred it is one of the crimes of the century;  
it is an incredible thing? Isn't that what you --

8

A. That was what was in my mind, yes.

9

Q. And we have also heard evidence

10

that there is no morphology when there is death by

11

digoxin. That means there is no anatomical evidence

12

on autopsy. And Dr. Phillips and Dr. Cutz have

13

testified you would have to have a high degree of

14

knowledge to know that.

15

Is that the type of thing you were  
considering?

16

A. Similar to that.

17

Q. Yes. And we also know that

18

digoxin mimics symptoms of other modes of death.

19

That type of knowledge?

20

A. Yes.

21

Q. So you were considering the

22

person who did this would have to have a tremendous

23

degree of clinical knowledge and medical or pathological

24

knowledge or else make an effort to obtain it? Is  
that right?

25





F.12

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A. That seemed obvious to me, yes.

3

4

Q. And that was your opinion to the police in 1982. Is that still your opinion today with regard to Phyllis Trayner?

5

6

A. Yes.

7

MR. KNAZAN: Thank you. Those are all my questions.

8

9

THE COMMISSIONER: Yes. Thank you, Mr. Knazan.

10

Miss Solomon, you have no --

11

MS. SOLOMON: No questions.

12

THE COMMISSIONER: Mr. Olah?

13

CROSS-EXAMINATION BY MR. OLAH:

14

Q. Good morning, Miss Coulson. I act for Janet Brownless the other registered nursing assistant on Ward 4A, and I just have a couple of questions.

15

16

17

Listening to your evidence you were fairly clear that by the last week of July you realized that there was a pattern forming on Wards 4A/4B. That was your evidence?

18

19

20

A. Yes.

21

22

Q. And you told us about the pattern; namely that children were dying in a time during the night and they were dying while the same team was on?

23

24

25





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A. Yes.

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Q. That was in relation to the  
five deaths that occurred in July. Am I correct in  
that?

5

6

A. I am not sure of the number but  
there was a cluster.

7

8

9

10

Q. All right. I can tell you that  
there were in fact in the month of July five deaths,  
Perreault, Bilodeau, Taylor, Dawson and Hoos that  
occurred on 4A and 4B.

11

12

Now in the month of August I had a  
little trouble deciphering the worksheet, Exhibit 351.

13

14

A. Are you referring to the time  
schedule?

15

16

17

Q. The time schedule, yes.

Do I understand that you were off for  
about a week in August? Do you have a copy of your  
worksheet there?

18

19

20

21

22

23

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Q. That's right. 1980.

3

A. What dates are you referring

4

to?

5

Q. I don't know. I had trouble  
deciphering my photocopy.

6

7

Were you off between the 7th of  
August and the 10th of August?

8

A. I was off for four days.

9

Q. Yes.

10

11

THE COMMISSIONER: I'm sorry, the  
7th of August, and what did you say?

12

THE WITNESS: I was off August 7th,  
8th, 9th and 10th.

13

14

THE COMMISSIONER: Oh, yes. Yes.

15

I'm sorry, are you not the third  
name on that?

16

THE WITNESS: No, the fourth name.

17

THE COMMISSIONER: I'm sorry.

18

19

MR. OLAH: No, that's Johnstone,  
Mrs. Johnstone.

20

THE COMMISSIONER: Yes. Yes.

21

22

23

24

25

MR. OLAH: Q. Now it was before you  
went on those four days of holiday I take it that you  
reported this pattern or concern that you were develop-  
ing to your superiors?







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A. It would have been during  
that week, if that was --

4

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Q. It would have been before  
you went on holiday that you made that report to your  
superiors?

6

7

A. Yes, because the deaths  
started on July 22nd, is that right?

8

9

10

11

12

Q. Well, there were three  
deaths. Taylor was July 27th; Dawson, July 28th and  
Hoos, July 31st. So I take it it was before you went  
on holiday that you reported this concern to your  
superiors?

13

14

A. Yes, because it would have  
been while I was there.

15

16

Q. And it was before you went  
on holiday that you discussed that concern with Mrs.  
Johnstone, when she returned from her holiday?

17

18

A. Mine was -- just to clarify  
this, mine were days off.

19

20

Q. Days off, all right. Four  
days off?

21

22

23

24

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A. Yes. Okay.

Q. But it was before you took  
your four days off that you had that discussion with  
Mrs. Johnstone about this pattern that you were  
observing developing on the floor?





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A. Yes, because she was back  
from vacation.

Q. And in fact she appears to  
have returned early in August before you had your days  
off.

A. Yes, she came back on the  
4th of August.

Q. Okay.

A. So I would imagine it would  
have been that night.

Q. Now we know that Baby Turner  
died on August 1, 1980, and you appear to have been  
on nights that evening.

A. That's right.

Q. And we also know that Baby  
Shrum died on August 9, 1980, and you were off. That  
was one of your four days off.

A. Yes.

Q. And similarly Baby Monteith  
died on August 18th, and you were off as I read your  
schedule on the 18th.

A. Yes.

Q. I'm sorry, that's the 19th  
actually.

A. The 19th of August?





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Q. Yes. Baby Monteith died on the 19th; not on the 18th, and you were off on the 19th.

A. That's right.

Q. But you were on when Baby Murphy died on August 23rd.

A. Yes.

Q. You were on when Baby Velasquez died on August 24th.

A. Yes.

Q. Now, when you came back from your days off, did you find out about the deaths of Babies Shrum and Monteith?

A. I am sure somebody told me.

Q. So were you aware by the end of August that in fact another five babies had died on those two wards?

A. By the end of August?

Q. In addition to the five that died in July.

A. Yes.

Q. And I guess if you had a concern about a pattern forming by the end of July, I guess that concern was heightened by the end of August?







Coulson  
cr.ex. (Olah)

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A. I would suspect so, yes.

3

4

Q. Was that something you  
addressed your mind to in late August or early  
September?

5

6

A. What, the pattern?

7

Q. Yes. This continuing  
pattern that you had observed first in late July.

8

A. I don't really remember.

9

10

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13

14

Q. Now we have heard evidence,  
Ma'am, that my client, Janet Brownless, did not start  
at The Hospital for Sick Children until August 25th,  
and that in fact the first time she was on the ward,  
because she was on a week of orientation, was  
September 2, 1980. Were you aware of that?

15

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A. I don't remember Janet  
Brownless, I don't remember when she started.

Q. I guess the point I am trying  
to make is simply this; that in late March when you  
first started suspecting that there was something  
possibly other than surgical deaths involved, it was  
pretty clear to you that that pattern that you observed  
in July was well-entrenched and well-established by  
late August?

A. Yes.

Q. And consequently Janet





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G6 2 Brownless could not have had any involvement in that  
3 because, assuming that the evidence is correct, if  
4 she started on Wards 4A and 4B in late August or early  
5 September, she could have had no involvement whatsoever?  
6 A. I would agree with that.  
7 MR. OLAH: Thank you. Those are all  
8 the questions I have.  
9 THE COMMISSIONER: Thank you.  
10 Mr. Shinehoft, you seem to be anxious.  
11 MR. SHINEHOFT: I am going first,  
12 Mr. Commissioner.  
13 THE COMMISSIONER: You realize that  
14 we are stopping at 12:45, do you? Does that disturb  
15 you?  
16 MR. SHINEHOFT: No. I hope it doesn't  
17 disturb you, Mr. Commissioner.  
18 THE COMMISSIONER: Well, it does a bit  
19 but I thought, to make your way clear for the afternoon,  
20 you have ten minutes to do it in.  
21 MR. SHINEHOFT: I think I can do it.  
22 THE COMMISSIONER: Good. All right.  
23 CROSS-EXAMINATION BY MR. SHINEHOFT:  
24 Q. Miss Coulson, my name is  
25 Jack Shinehoft, and I represent the parents of the  
the baby, Kevin Pacsai. I have just a few questions





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to ask you.

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One area that I would like to canvass with you is the question of administration of drugs, of the medications. You indicated in your previous evidence that it was not right for Nurse A to sign for Nurse B if in fact Nurse A had administered a drug; is that correct?

8

A. That is not acceptable.

9

Q. It is unacceptable?

10

A. It is unacceptable practice.

11

12

Q. But you say a couple of things about that. You say, first of all, that it is done on occasion; is that right?

13

A. Yes, on occasion.

14

15

16

17

18

19

Q. Now, is it okay, Ma'am, for Nurse A to sign Nurse B's name but for Nurse A? In other words, if one were to give the drug, ask a second person to sign their name and that person would indicate that it wasn't they that gave the drug but in fact the first nurse?

20

A. You have lost me.

21

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Q. Okay. Nurse A would administer the drug and ask Nurse B to sign her name; would it be okay for Nurse B to sign Nurse A's name per her name?





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A. Wait a minute. Who gave the drug?

Q. Nurse A administered the drug.

A. Okay. Nurse A administered the drug?

Q. Yes, and asks Nurse B to sign her name.

A. No.

Q. You say that would not be proper as well, even though --

A. If Nurse A gave the drug, Nurse A should sign the drug.

Q. Okay.

A. If Nurse A was looking after the patient and Nurse B gave the drug --

Q. Yes.

A. -- and Nurse A signed for it --

Q. Yes.

A. -- Nurse A could sign --

Q. Nurse A could sign Nurse B's name?

A. No, she would sign her name. She may have signed the drug. If I gave the drug -- say you were a nurse and I gave --







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Q. Thank you. Mr. Commissioner,

I wish I were a nurse!

A. -- if I gave the drug for  
you and you signed it --

THE COMMISSIONER: What Mr. Shinehoft  
wants to do is sign your name per Jack Shinehoft; that  
is what he wants you to do.

MR. SHINEHOFT: Q. Is that  
acceptable?

THE COMMISSIONER: He is really  
stating what happens, but the actual administrator is  
not signing although she is authorizing presumably.

THE WITNESS: If you gave the drug  
for me?

THE COMMISSIONER: No, no.

THE WITNESS: Now I am confused.

THE COMMISSIONER: You give the drug  
for Mr. Shinehoft.

THE WITNESS: If I gave it for him --

THE COMMISSIONER: Just pause there.  
Remember, you are a nurse and he is a nurse and you  
have given the drug but he was supposed to give the  
drug - have we got it so far? Okay. Do you have it  
so far?

THE WITNESS: Yes. If I give the drug.





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THE COMMISSIONER: If you give the  
drug and he was supposed to give the drug.

4

THE WITNESS: That's right.

5

THE COMMISSIONER: But you gave the  
drug because he asked you to.

6

THE WITNESS: That's right.

7

THE COMMISSIONER: The next thing  
he says, he says, Miss Coulson, would it be all right  
if I signed your name and put it through per my  
initials. Now, this may never have happened in the  
long history of nursing.

11

12

MR. SHINEHOFT: Well that is my  
next question, Mr. Commissioner.

13

14

Q. First of all, is that  
acceptable?

15

16

A. If I gave it and you signed,  
giving K. Coulson, per you; is that acceptable?

17

Q. Have you ever seen that done?

18

19

A. Yes, I have, because nurses  
will do it for doctors, and I have done it for another  
nurse.

20

21

Q. And there is nothing improper  
or wrong with that?

22

23

A. As long as I have indicated  
that I have given it.

24

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Q. Why would it not be done all

3

the time then, instead of having the nurse who did not

4

administer the drug sign off, and as the Commissioner

5

has pointed out, we would never know who actually

6

administered the drug. Can you give me a reason why --

7

A. I can't give you a reason.

8

Q. But you say you have on

occasion signed on behalf of doctors and other nurses?

9

A. Yes.

10

MR. TOBIAS: Just so we don't get

11

confused, is she indicating that she has signed for

12

doctors or other nurses, indicating "per" her own

13

initials?

14

THE WITNESS: Yes.

15

MR. SHINEHOFT: Q. You indicated,

16

Miss Coulson, that you had concerns about a number of

17

the deaths and that you had spoken to certain people,

18

supervisors and Dr. Costigan was one of the doctors

19

that you spoke to. What did you say to them, if you

20

can recall? Did you talk about numbers? Did you talk

21

about the time? Did you talk about the ward? Did

you talk about the nursing teams? Do you recall?

22

A. I can give you a general --

23

Q. Sure, if you could.

24

A. -- but I can't give you a

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Coulson  
cr.ex. (Shinehoft)

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specific.

Q. Right.

A. I remember saying that it was always the same team of nurses, that it was always during the night; that we got so we were watching the clock.

Q. Anything else.

A. It always happened at the same time and the same nurses.

Q. Those are basically the general areas of discussion that took place between you?

A. And the same floor. Yes.

Q. You gave evidence that after the arrest of Baby Manojlovich you went into the room of Kevin Pacsai.

A. Yes.

Q. And you gave evidence that you saw Susan Nelles, you saw Lynn Johnstone, Mary Jean Halpenny.

A. Lynn Johnstone and Mary Jean. Mary Jean was the charge nurse on 4B that night.

Q. What about Sue Lyons? Was she not in fact in the room?

A. I don't know.





G13

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Q. Do you know her?

3

A. I can't put a face to her.

4

Some of the names and faces I can't keep together.

5

Q. Is it possible that she was

6

there?

7

A. If she was on duty, it's

8

possible.

9

Q. She gave evidence at the

10

preliminary hearing, and I can refer you to the

11

volume as well - it is Volume 8, page 106, line 8 -

12

that she was in fact in the room. You wouldn't

disagree with that, would you?

13

A. No, I wouldn't disagree.

14

Q. When you first heard of the

high dig. level that Kevin Pacsai had, I understand

15

you heard it from Susan Nelles; is that correct?

16

A. That's correct.

17

Q. Did you in fact receive the

18

information as to the level that he had?

19

A. No, I didn't.

20

Q. You now know what his levels

were, do you?

21

A. 25.

22

Q. He had a post mortem of level

23

of approximately 25 and an ante mortem level of greater

24

25





1  
G14 2 than 10. Were you aware of that?

3 A. Yes.

4 Q. Do you have any opinion as to  
5 how this level could be achieved? In other words,  
6 is it -- do you have an opinion as to whether this  
7 level could be achieved through an accidental  
8 administration of the drug? Would you care to comment  
9 on that?

10 A. I don't want to comment on  
11 that.

12 THE COMMISSIONER: You may be safe.  
13 Yes, you were.

14 MR. SHINEHOFT: Q. When you first  
15 went into the room that Kevin Pacsai was in -- I believe  
16 it is Room 431; is that not correct, after the  
17 arrest of Manojlovich?

18 A. The room right next to the  
19 nursing station on the 4B side, I think it is 431.

20 Q. -- was Dr. Costigan already  
21 there?

22 A. He either came in at the  
23 same time or he was there; I don't remember.

24 Q. Do you recall what he was  
25 doing?

A. When he was there, he was





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examining the baby.

Q. And what were you doing?

A. I came in to see what was going on.

Q. You took no active role? You were there only as an observer?

A. That's right.

Q. And did you leave before Dr. Costigan or vice versa?

A. No. I left before he did.

Q. Could you comment about the clinical condition of the child when you left the room.

A. The only thing that stands out in my mind is he was doing some funny things, but I can't remember; I would have to look at the chart, but he was being looked at by Dr. Costigan.

Q. And prior to that one time that you saw the child, you had never seen the child before, had you?

A. I walked in once before during the night. I remember going into the room because -- he stands out in my mind because he was a bigger baby than Inwood, who was in the next -- I saw that he was small.

---







/BM/ak

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Q. Okay. So, you saw him for the  
second time after the arrest?

4

A. After the one down the hall?

5

6

Q. Right. What was his condition  
the first time that you saw the baby?

7

A. He was sleeping, fine.

8

Q. There was no problems?

9

A. Didn't seem to be a problem.

10

MR. SHINEHOFT: Those are my  
questions, thank you very much.

11

12

THE COMMISSIONER: Thank you very  
much. Then we will rise until 2:15.

13

---Luncheon recess.

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--- on resuming at 2:15 p.m.

THE COMMISSIONER: In this Commission, I am charged with the task of determining how and by what means 36 children who died in the Hospital for Sick Children between June 30th, 1980 and March 22nd, 1981 came to their deaths. My mandate includes reporting on the circumstances of the investigation and prosecution of charges laid against one Susan Nelles with respect to 4 of those deaths.

The hearing has been in session almost continuously since June 21st, 1983 last and throughout that period the Registered Nurses Association of Ontario, the Attorney General and the Metropolitan Toronto Police among many others have had standing and have been represented by counsel. A complaint has now been made by Counsel for the Attorney General and Counsel for the Metropolitan Toronto Police relating to the conduct outside the hearing of an official of the R.N.A.O. and of one of the Counsel for that organization.

I should say at the outset that the complaint in my view is justified but the improprieties were not of such magnitude that the whole matter could not have been disposed of very simply by a mild condemnation and ideally by an expression of regret





1  
2 and an undertaking to try to avoid a repetition.

3 (Indeed Mr. Hunt for the Attorney General sought no  
4 remedy except the expression of my views.) Unfor-  
5 tunately the attitude of Ms. Kitley, Counsel for the  
6 R.N.A.O. has made that simple solution impossible. I  
7 must deal with the matter in detail and at some  
8 length.

9 The official concerned is one Allie  
10 Lehmann who was interviewed by a Mr. Soles of the  
11 Canadian Broadcasting Corporation and there proceeded  
12 the following exchange:

13 MR. SOLES: "Allie Lehmann of the Registered Nurses'  
14 Association of Ontario says the nurses  
15 are being unfairly portrayed as unco-  
16 operative. She says that nurses are  
17 having to take the rap for bungling by  
18 the Police and the Attorney General's  
19 office.

20 Allie Lehmann joins us in the studio now.  
21 Good evening, Miss Lehmann.

22 MISS LEHMANN: Hi, Paul.

23 MR. SOLES: Why is it you feel that nurses  
24 aren't being given a fair hearing at the  
25 Grange Commission?

MISS LEHMANN: Well, I think it is quite  
evident from the kind of examination that  
went on today that lawyers for the  
Attorney General and the police are trying  
to blame nurses for their own inept investi-  
gation. And rather than look at a lot of  
other Hospital personnel that may have been  
associated with the infant deaths, it's  
only nurses that are taking the rap and  
they are being grilled very comprehensively."







1  
2 And further:

3 MR. SOLES:

4 "How can you ask the lawyers to or can you  
5 ask the Chair to restrain the temper and  
6 tenor of the questions?

7 MISS LEHMANN: Well, I don't know that we  
8 can do much about it. Our lawyers certainly  
9 object when, for instance, when Barry  
10 Percival fires rapid fire questions three  
11 in a row without the witness being able to  
12 answer one. She does object to that. But  
13 what I really object to and what other  
14 nurses today in the gallery today objected  
15 to is that they're trying to portray Ms.  
16 Bell as not being a co-operative witness  
17 and this came about with Douglas Hunt's  
18 testimony (sic). That in fact because her  
19 memory of what happened three years ago  
20 and sometimes four ago did not necessarily  
21 jive with what happened now. She was made  
22 to look as though she had been obstructing  
23 the police investigation. And that's  
24 patently false. Nurses were doing the best  
25 that they could to help the police. But  
the circumstances during the investigation  
need to be brought out. And the thing is  
that nurses were frightened. They were  
stressed. They were treated quite shabbily  
and they did not have any legal counsel  
during the preliminary or during the police  
investigation. That's a very critical point.

Now I was just saying that often during the  
investigation a police said, was said today,  
that police came up to the ward to try to get  
Bertha Bell to go to an interview with them  
and she said I can't leave the ward, there's  
nobody to relieve me. Who's going to take  
care of the babies. You know they have no  
concept that nurses were dealing on a minute  
to minute basis with the babies in their  
care and they were trying to give the best  
care that they could."

22 And:

23 MR. SOLES:

24 "As I hear you speaking one wonders if indeed  
25





1  
2 the Chair or your counsel might attempt to  
3 make what you've just said clear to the  
4 Commission rather than letting it sit as a  
grilling or leaving the impression of unco-  
operation.

5 MISS LEHMANN: Well, I think that our counsel  
6 does get a chance during cross-examination,  
7 but our counsel won't be cross-examining  
8 until tomorrow, and that leaves two days of  
an impression in the public's mind that  
nurses were possibly being unco-operative.  
And I want to say that I think that nurses  
are sacrificial lambs in this entire  
process."

9 And again:

10 "MR. SOLES: Miss Lehmann, what is your  
11 expectation about the style and toughness  
of questioning as the Commission hearings  
go on?

12 "MISS LEHMANN: I think we can expect that  
13 nurses are going to be grilled from hereon  
in. The place is packed with nurses,  
14 press, and that is going to continue as  
well. There are a lot of lawyers who want  
15 to show the press in fact and the media, they  
want to make a good show for the media. I  
16 find that offensive myself but I don't know  
if there is anything we can do about that.  
You see, it is a public inquiry and we  
17 welcome the media being present but we want  
them to report responsibly and accurately and  
18 in context, that is probably the most  
important thing.

19 "MR. SOLES: Is the tactic of your own  
20 counsel then to give in kind when they get  
a chance?

21 "MISS LEHMANN: Well, yes. I mean, I don't  
22 think that they act the same way as for  
instance the lawyers for the Attorney  
General and the Police have acted, but our  
counsel is acting responsibly."

23 There is no question that the statement of  
24  
25





1  
2 Miss Lehmann imputed misconduct to the police, to Mr.  
3 Hunt and to Mr. Percival and it is not an unreasonable  
4 inference that it imputed misconduct to the Commission  
5 as well.

6 The complaint with regard to Miss Kitley  
7 arises out of a report in the Hamilton Spectator of a  
8 speech made by her. Portions of the article are as  
9 follows:

10 "Even the provincial Royal Commission headed  
11 by Mr. Justice Samuel Grange, which is to  
12 discover "how and by what means" the  
13 children died, and what went wrong, if any-  
14 thing, in the investigation of the deaths  
15 has turned into "a non-murder murder  
16 inquiry," lawyer Fran Kitley told an  
17 audience of 350 nurses last night at Chedoke  
18 Hospital.

19 "The Toronto lawyer, who represents 39  
20 individual nurses and the Registered Nurses  
21 Association of Ontario at the Grange  
22 Commission said: "We do not know it was  
23 murder. But everyone is assuming that there  
24 were 36 murders and it had to be a nurse."

25 And further:

"Ms. Kitley told the nurses the inquiry  
"appears to be trying to point a finger.  
And everyone of us here tonight knows it  
could have happened to one of us."

Ms. Kitley does not dispute the accuracy of  
the report. It is certainly a possible inference from  
those remarks that the Commission itself is attempting  
to prove the guilt of a particular nurse having chosen  
her apparently at random.







1  
2 As I have said, I do not consider these to  
3 be very serious transgressions but I do consider them  
4 to be improper. It is unfair for a client to speak to  
5 the media maligning another party and that other  
6 party's Counsel when they are not present to reply and  
7 have very properly not put their position to the  
8 media, saving that for the Commission. It is improper  
9 for Counsel to permit her client to make derogatory  
10 remarks about another Counsel to the media. It is  
11 improper for Counsel to say anything, particulalry in a  
12 speech covered by the press to 350 persons, from which  
13 it might be inferred that the Commission is operating  
from a preconceived bias or in bad faith.

14 But what concerns me most is not what was  
15 said by Ms. Kitely or her client but Ms. Kitely's  
16 attitude to the complaint. These are her precise words:

17 "In my submission it is not something for  
18 you, sir, to deal with. Ms. Lehmann is  
entitled to make statements, as is Mr. Hunt,  
as is Mr. Percival, sir. It is not as if,  
sir, we are before a court of law and a  
trial judge."

19 And again:

20 "Might I start from the beginning as it  
21 were in the sense that when you granted  
standing to the Registered Nurses' Associa-  
22 tion in May I am assuming it was because  
you agreed that the Association had an  
interest in the proceedings. Might I say  
23 that the Registered Nurses' Association is  
an organization of approximately 42,000  
24  
25







1  
2 members, Registered Nurses in the Province  
3 of Ontario. In order to keep its members  
4 informed the Association uses various  
5 methods of communication.

6 "The membership has been divided by the  
7 organization into 10 sections in the  
8 province. In each of those 10, meetings  
9 have been held or will be held to inform  
10 members of the RNAO of the proceedings at  
11 this Inquiry. These meetings are or will  
12 be addressed by a member of the Association  
13 and by one of their Counsel at these pro-  
14 ceedings. (The emphasis are my own. I  
15 presume that the Counsel referred to are  
16 Ms. Kitley's partners, Mesdames Symes and  
17 McIntyre who have also represented the  
18 R.N.A.O. at this Commission.)

19 I continue with quotations from Ms. Kitley's argument:

20 "Hamilton was the first of these. The  
21 report in the Hamilton Spectator that my  
22 friend brought to your attention yesterday,  
23 which is dated January 31st, arose out of  
24 a meeting in Hamilton on January 30th.

25 "The area association members expressed a  
keen interest in the topic, as was  
evidenced by the attendance of some 350  
people and many questions from the floor.  
There will be nine more of such meetings in  
the province.

"The Registered Nurses' Association does not  
have a policy of holding meetings where the  
press is excluded and consequently press  
did attend the meeting in Hamilton.

"Aside from such meetings as these, the  
Association communicates with its 42,000  
members by use of the media. The RNAO has  
used and continues to use the media to in-  
form its members about important nursing  
issues such as the Canada Health Act and  
the Reform of the Health Disciplines Act.

"The RNAO has the right to use the media  
in this fashion and the members of the





1  
2 RNAO have the right to be kept informed.  
3 In my respectful submission, the statements  
4 as reported in the Hamilton Spectator and  
5 those taped on the CBC and provided to you  
6 by my friend on Monday do not violate any  
7 rules or standards. I can assure you that  
8 no statements were made with any intention  
9 to offend you as Commissioner or this  
10 Commission; rather, they were made to  
11 communicate the Registered Nurses' Associa-  
12 tion's views on what this Commission means  
13 for nursing and were made in the exercise  
14 of the right of free speech which we now  
15 all know is guaranteed by the Charter.

16  
17 "In my respectful submission no impropriety  
18 has been committed. While I have con-  
19 sidered your comments of Monday, it is my  
20 submission that our clients, the Registered  
21 Nurses' Association, is not out of control.

22  
23 "The Registered Nurses' Association, its  
24 spokesman, in this particular occasion  
25 Allie Lehmann and counsel for the RNAO  
ought not to be restricted or prohibited  
from communicating freely and openly to its  
members in the media. Such a restriction  
would violate the right of free speech.

"In my respectful submission, the Associa-  
tion has the right to speak out and has not  
acted in a manner which is irresponsible,  
unprofessional or improper."

Miss Kitley went on to justify her position  
by pointing to reports in newspapers and transcripts of  
radio and television programmes in which commentators  
reported on the proceedings or expressed their views  
upon the proceedings. There were also some excerpts  
from interviews given to the media by other Counsel.  
Most of these latter were responsible; there was an  
occasional tendency to try the case in the Press which





1  
2 is always unfortunate but there was certainly no  
3 reflection upon the integrity of other Counsel or the  
4 Commission.

5 It is my view that Ms. Kitley and those  
6 who support her have missed the point entirely. The  
7 complaint has nothing to do with freedom of expression  
8 or freedom of the press, concepts that were with us  
9 long before the Charter of Rights and Freedoms was  
10 ever thought of. Subject to the law of defamation,  
11 I can have no objection to any member of the public  
12 or of the media expressing his views not only on the  
13 nature of the Inquiry and the evidence but also the  
14 propriety or fairness of the proceedings. Some of the  
15 comments made display little more than the ignorance  
16 of the commentator upon the facts, the law or the  
17 issues but some of them are both well-informed and  
18 intelligent, and I have profited from them. But  
19 whether the comments are favourable or unfavourable,  
20 good or bad, destructive or helpful, the commentators  
21 have a right to make them, a right that I and all of us  
22 here are pledged and determined to preserve.

23 What this is all about is not freedom of  
24 speech but legal ethics, courtesy, fairness and pro-  
25 fessional conduct.

As put by Mr. Tobias:

"What we are really talking about here is









1  
2 the appropriateness of the comments that  
3 are made, the respect those parties have  
4 for the whole process and for the dignity  
5 of the process, and more importantly, the  
6 responsibility of counsel in terms of what  
7 their clients are saying to the press."

8 I need only add that the obligation of  
9 Counsel is all the stronger when the words complained  
10 of are not the clients' but his own.

11 Ms. Kitley is a lawyer and bound by the  
12 ethics of her profession. She owes a duty of courtesy  
13 and fairness to the Court and to her fellow Advocates.  
14 She says that this is not a Court of Law and of course  
15 she is right. But that does not diminish my power as  
16 it is put by Mr. Lamek to express my disapproval of her  
17 conduct and to say to her as I do now and I regret to  
18 have to say it that I find in her statements and those  
19 she has permitted her client to make something in-  
20 consistent with her duty of courtesy to me and her  
21 fellow Counsel. It may be that as a Commissioner I have  
22 not the same power of discipline as I have as a Judge  
23 but I have never heard and I refuse to accept that the  
24 fact that Counsel is appearing before a Commission  
25 somehow diminishes his obligation of courtesy, fairness  
and good faith nor his obligations to conduct himself  
in a professional manner.

There has also been put forth the





1  
2 suggestion that because the Inquiry has evoked much  
3 media interest and considerable publicity, Counsel  
4 are freer to express themselves regardless of the  
5 niceties of their Profession. I cannot speak too  
6 strongly against that proposition. The fact that this  
7 Commission is under close public scrutiny should if  
8 anything make Counsel more anxious to demonstrate to  
9 the public the high standards of our profession. If  
10 they allow their standards to fall because of the  
11 publicity, then this experiment in full exposure will  
12 have proved a dismal failure.

13 Having expressed my views that should be  
14 the end of it. However, I must face the prospect that  
15 Ms. Kitley and her partners will notwithstanding my  
16 views continue in their course of conduct. Not only  
17 is there the expressed contention noted above but on  
18 the Monday following the argument, Ms. Kitley read to  
19 me a statement which she said had been carefully worded.  
20 It is in full as follows:

21 "I have reviewed the transcript of the  
22 hearing on February 16th, with Gail Paech,  
23 President of RNAO. She and I have con-  
24 cluded that the controversy over statements  
25 made outside the hearing room is unfortunate  
and may detract from the important issues  
before the Commission.

On Thursday, I indicated that there was no  
intention either on my part or the part of  
representatives of the RNAO to offend the





1  
2 Commissioner or this Commission.

3 I would like to emphasize this lack of  
4 intention. The President of the RNAO and  
5 I regret that offence has been taken either  
6 by you, sir, or by other Counsel at this  
7 hearing.

8 We hope that this expression of regret  
9 will assist in bringing this controversy  
10 to an end."

11 That statement in my view is more revealing  
12 in what it doesn't say than in what it does. It does  
13 not express any lack of intention to offend Counsel  
14 although this might have been an oversight. Most  
15 important, however, it makes no pledge of future  
16 conduct. When pressed on the matter, she said the  
17 R.N.A.O. was too large for her to give any undertaking  
18 as to their conduct. She further said she could give  
19 no undertaking as to her own. I can only infer that  
20 she has no intention of trying.

21 Ms. Kitley has suggested that my only  
22 remedy is to report the matter to the Law Society.  
23 I am not sure that that would be appropriate. The  
24 Law Society might well respond that I should deal  
25 with the matter myself. The remedy under S8(c) of the  
Public Inquiries Act might be more appropriate.

I have just one more thing to say. This is  
not an easy task and it is made immensely more difficult  
by the continued preoccupation with the conduct of a







1  
2 particular Counsel. I find that conduct not only  
3 improper but incomprehensible. It cannot possibly  
4 be (as a moment's reflection would tell her) in the  
5 interests of her client. But my prime interest is the  
6 integrity of this Commission and the completion of the  
7 task assigned to it. It has been my hope to be  
8 assisted in that task by Counsel but it must be done  
9 with or without that assistance. The conduct complained  
10 of does not assist; indeed it hinders us without in  
11 any way assisting the client's cause. I cannot and  
12 will not tolerate its repetition.  
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Now would the witness come forward,  
please?

Mr. Labow, I think you are up now.

KATHLEEN COULSON (Resumed)

CROSS-EXAMINATION BY MR. LABOW:

Q. Good afternoon, Miss Coulson.  
My name is Stephen Labow and we represent the parents  
of six children who died on the wards.

Now according to Exhibit 352 you were  
in charge of Ward 4A/B for three of those children:  
Turner, Gionas and Inwood?

A. That is right.

Q. Now I have the only copy of the  
tour end reports that I understand is down here, and  
I would like to ask you a few questions about the  
reports generally.

This is the first time I have seen  
them, and it is my understanding that the supervisors  
are the only ones who write anything on these reports?

A. That is not true.

Q. Well, can you tell me who does?

A. Usually the charge nurse fills  
the tour end report out during the day and it is  
usually the charge nurse that writes the status of  
the children and the staffing and whatever is





BB.2

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pertinent late afternoon or mid afternoon and the evening supervisor responsible for the area writes comments as does the night supervisor.

4

5

Q. Now when would you as a night supervisor put your comments into the tour end report?

6

7

A. When I come on duty. When I make my rounds.

8

9

Q. Just, for example, in some of these reports where a child is noted you will have a note aside another note in a different handwriting that a child died at a specific time?

10

11

12

A. Yes.

13

Q. Would you write that in if the child died during the night?

14

15

A. On my shift, yes.

16

It is usually done - there are different colours. It didn't come out on your copy there.

17

18

Q. No, I am going to give you this copy so you can refer to it.

19

I have a little piece of paper in for the three children I am concerned about.

20

21

A. Okay.

22

Q. Now my original understanding about these reports was that the sickest children would be noted specifically?

23

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A. Usually.

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Q. Who else would be noted?

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THE COMMISSIONER: Excuse me a moment,  
Mr. Labow. Did everybody get a copy of these?

5

6

MR. LAMEK: No, Mr. Commissioner. I  
am afraid there has been some trouble doing the  
copying and binding of them. They are not yet  
available.

8

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THE COMMISSIONER: Oh, I see. You I  
take it have them?

11

12

MR. LABOW: I have looked it over and  
I have given a copy to the witness.

13

THE COMMISSIONER: Yes. All right.

14

MR. LABOW: Q. Is it not only the  
sickest children who appear on any given day?

15

16

A. No. It would depend - a lot  
depends on the unit and what their usual practice is.

17

18

19

Some units put admissions - at this  
point in time some people put the admission, any  
admission on the tour end report. Also if the child  
was going for surgery or a special test.

20

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Q. What was the practice of 4A/B  
at the time that we are interested in?

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A. From what I remember the  
admissions were - admissions or transfer from Intensive







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Care were on the tour end report if there was concern.

Q. Okay. The first one I have marked which is on page 17 and 18 deals with Philip Turner.

Now he is noted on page 17 which is for the 30th of July.

A. Yes.

Q. As being stable. There are a number of comments and then it says "stable".

A. Yes.

Q. Is that correct?

A. Yes.

Q. On the next night, the 31st, he is unstable and it notes "should go to ICU". Do you know who wrote that note?

A. I can make a guess. I can't say for sure.

Q. You didn't write it?

A. I didn't write it.

Q. When you would come on did you see that note? Is that something that the nurse in charge during the day wrote or the evening supervisor wrote?

A. I would assume it would have been the day person.





BB.5

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Q. Okay. When you reviewed it that night he was still on the ward. Did you do anything with regard to that note?

5

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A. I didn't - anything that is written down here does not look like my writing, so, no.

7

8

9

Q. What I am asking you, if you came on as a night supervisor and the note in the tour end report said "should go to ICU", what would be done? Obviously someone thinks the child should go to ICU.

10

11

12

13

A. Somebody, on what I would assume looks like the day shift, suggested that the child go to ICU, and that would be up to the doctors to decide whether or not the child went to ICU.

14

15

Q. Would you check that out when you came on?

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A. I would check with the nurses.

Q. Do you recall if you checked?

A. I don't remember.

Q. You don't remember?

A. No.

Q. Now the arrest note which is on page 52 of the Hospital record. It should be beside you.

A. This one?

MR. LABOW: I have asked the Registrar to put it down there.





BB.6

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THE COMMISSIONER: Which one?

3

MR. LABOW: Philip Turner.

4

THE WITNESS: What page?

5

6

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MR. LABOW: Q. 52. The arrest note at the very top of the page is Dr. Izukawa's note, and the doctor pointed out that the child's cardiac status appeared controlled.

8

9

Do you have any idea why there was a suggestion that this child be transferred to ICU?

10

11

12

A. Only from the note that was on the tour - from the note on the tour end sheet. That is all I could go by.

13

14

15

Q. By looking at that note do you have any idea why there was a suggestion? Is there any indication in that note as to why there was a suggestion he should be transferred to ICU?

16

17

A. Do you want me to read the note out?

18

Q. No.

19

20

A. It says here that the child had a total collapse of left lung. Colour was fairly good but the child was working hard.

21

22

Q. Would that be enough to in your estimation have a child transferred to ICU?

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A. I couldn't say because it would





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have to depend on the doctor's examination.

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Q. If you read a note like that  
when you came on duty would you take special care in  
looking at that child? Would you go in and look at  
the child more carefully?

A. I would go and have a close  
look at the child, yes.

Q. But you don't recall or do you  
recall anything about this child?

A. I don't recall.

Q. That night?

A. No.







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Q. The last of those three markings is about Kristin Inwood. Now, on page 150, which is the note for the 11th of March, it notes that Kristin Inwood was admitted from the Toronto East General. There is a note indicating: "To ICU 0600". Did I read that note on the right?

A. Yes.

Q. Do you have any idea what that note involves?

A. That was on the 11th?

Q. Apparently.

A. I would imagine the child was transferred to the ICU at 6 o'clock in the morning.

Q. From what we have heard to date that did not happen. Would that be a note indicating the child should go to ICU; or that the child was expected to go to ICU; or is that a note that would normally be written after the child went to ICU?

A. I would say that when - if I could just check my time schedule.

Q. Certainly.

A. It doesn't look like my writing but I can't be sure.

Q. Apparently Lynn Johnstone was on.





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A. Okay. Then I can't answer for Lynn because it wasn't - I can hazard a guess but that is all I can do.

Q. Now, the next night, which is the night of the 12th, when you were in charge of 4A/B.

A. Yes.

Q. It is noted that the child had a digoxin level of 2.6 and digoxin was on hold?

A. Yes.

Q. Were you told that the child had mistakenly received a dose of digoxin, that you recall.

A. She had been a given a dose the morning before the night of Pacsai --

Q. Correct.

A. And I knew about that drug error, yes.

Q. Now, would a 2.6 level, in your experience, would a child with the 2.6 level normally have their digoxin put on hold?

A. I would say, yes.

Q. Now, when this child died do you have any recollection about your response to the Code 25 that was called?

A. I remember going to the room





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after the code was called. The only other thing I remember is the fact that it was a child that the drug error had been made on the morning before.

Q. Do you recall if anyone considered doing a postmortem blood sample because of that, to see if the digoxin level was still high?

A. I don't remember that, no.

Q. Do you recall any discussion after that about this being the child that had received a mistaken dose of digoxin?

A. I remember hearing it but I don't remember the exact time. I just know it was the child that had had the drug error made.

Q. Did you, or do you recall anything about the arrest in that there was apparently very little response from this child?

A. I don't remember, no.

Q. The last child I would like to look at is Barbara Gionas. Now, Barbara Gionas appears on the tour end reports from the 27th of February until the 8th of March. On the 27th and the 28th it appears that she was on shared nursing care, am I correct in that?

A. What is the date again?

Q. The 27th and it is page 131.







1

2

CC4

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4

A. Oh, okay. Shared nursing care for how many days, do you want me to go over them?

5

6

7

Q. Apparently for two, but I would like it if you will check to see if my reading is correct.

8

9

A. She was also on shared nursing care on the 1st of March, the 28th of February, the first of March, that would be three.

10

11

12

13

Q. Those were the only three days. If she was on shared nursing care for the first three days and taken off, would that indicate that she was improved somewhat?

14

A. I would say so.

15

16

17

Q. Now, I have read through them and most of the notes indicate that she was stable and that there had been no change from the previous day.

18

A. Yes.

19

20

21

Q. Until the 8th, which is page 140. Now, the note setting out: "apex irregular - stable - arrest, expired 0145", is that your note?

22

A. It doesn't look like my writing.

23

24

25

Q. But you were the supervisor





1  
2 in charge that night?

3 A. Yes.

4 Q. If you didn't write the note  
5 who would have written the note generally?

6 A. It could have been one of the  
7 other supervisors.

8 Q. Now this is one of the two  
9 children that you think you have narrowed down to  
10 regarding the strange incident with the doctor and  
the IV bag?

11 A. Yes.

12 Q. Now I note from the - you have  
13 indicated that you remembered one other supervisor  
14 being with you when that incident occurred.

15 A. I remember seeing her in the  
16 door, yes.

17 Q. Does that mean that she was  
18 the only supervisor who was on that night?

19 A. No, not necessarily.

20 Q. So if Miss Carter was on the  
21 night that Gionas died, as well as Miss James, that  
22 doesn't mean that it wasn't this child, you can't  
eliminate one or the other because of that?

23 A. No, I can't.

24 Q. Now, you indicated that the  
25





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doctor told you he was going down to the lab to test  
this.

4

A. From what I can remember he  
was taking the IV bag down to the lab for testing.

6

Q. Now, have you gone through  
the charts of those two children carefully?

7

8

A. Yes, I have.

9

10

Q. And do you agree with me that  
there is no test, or no test result for anything,  
including potassium, after the days that this child  
died?

11

12

A. From what I have gone over I  
don't remember seeing a result, no.

13

14

Q. Now if that kind of test was  
done would the chemistry report appear in the  
Hospital record generally?

15

16

A. If they requisition --

17

18

Q. If a doctor had taken down  
an IV bag with regard to Baby Gionas, and asked for  
them to do a test to tell them what the potassium  
level was, would you expect the results of that test  
to be in the Hospital record?

19

20

21

A. In a record somewhere, yes.

22

23

MR. LABOW: I have no further  
questions.

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THE COMMISSIONER: Thank you. I am just wondering about that. Would that necessarily result, would the doctor not just go down and say, will you please test this for me and let me know?

THE WITNESS: He might, but it would be somewhere in the record.

THE COMMISSIONER: It would be in a record, but I think the question was, would it be in this?

THE WITNESS: On this record, not necessarily.

MR. LABOW: Q. If it wasn't in the Hosiptal record where would you expect it to be?

A. I'm sorry, I misunderstood what you said.

Q. I'm sorry, if it wasn't in the Hospital record, this is, from our understanding the Hospital record, the Hospital chart.

A. I thought you said a hospital record.

Q. What record would you expect to find it in?

A. I would think that if someone in Chemistry did a test on a bag of IV fluid that they would have a record somewhere that they







1  
2 tested that IV bag, that is what I understood you  
3 to say.

4 MR. LABOW: I hate to do this,  
5 Mr. Commissioner.

6 THE COMMISSIONER: Maybe Miss Thomson  
7 can do this too.

8 MR. LABOW: Is it possible to just  
9 check for these two children to see on those dates  
10 if there is a record in the Chemistry Lab for this  
11 kind of test.

12 MR. ROLAND: We can have a look,  
13 Mr. Commissioner. It may not have been the Chemistry  
14 Lab at all, it may have been the Pathology. The  
15 baby was dead at that stage and it may very well  
16 be - because the practice as I understand it is to  
17 do most of the testing, any kind of testing done in  
18 Pathology. So it may have been in the Pathology  
19 Department. We just don't know.

20 What I can tell you is we have been  
21 trying assiduously for the last 24 to 48 hours to  
22 track down who the doctor was that the witness has  
23 been referring to and we so far have not come up with  
24 anything. We have all been examining the signature  
25 closely and we thought we knew the doctor, we spoke  
to the doctor, from the signature we spoke to him at





1  
2 lunch time and he says it isn't his signature and he  
3 doesn't know anything about it. There is, your own  
4 staff have indicated that they think it is a certain  
5 doctor who we now know is in Switzerland.

6 THE COMMISSIONER: Complete with  
7 the bag.

8 MR. ROLAND: Miss Thomson said she  
9 would be happy to speak to that doctor personally,  
10 but we are not yet prepared to let her do that. So  
11 we really are having a very difficult time connecting  
12 anybody to this event. But sure, we can have a look  
13 in the lab, it is something that is not easy to do  
because it is not kept by infant.

14 THE COMMISSIONER: No. It would  
15 be kept by date presumably.

16 MR. ROLAND: Presumably, and we  
17 will see what we can find.

18 THE COMMISSIONER: If Miss Coulson  
19 is right and it is one of those two babies we really  
can't do any more than those two dates.

20 MR. ROLAND: That's right, it is  
21 an impossible task otherwise.

22 THE COMMISSIONER: Yes. All right.  
23 Thank you.

24 MR. LABOW: That is all I would  
25





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ask, Mr. Commissioner.

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THE COMMISSIONER: Yes, thank you,

4

Mr. Labow. Mr. Shanahan?

5

CROSS-EXAMINATION BY MR. SHANAHAN:

6

Q. Miss Coulson, my name is

7

Shanahan and I act on behalf of the Dawson and

8

Lombardo families.

9

First of all it seems to me that

10

with respect to Baby Lombardo there is two areas

11

where that baby appears significantly in your evidence.

12

The first of them is in response to the question from

13

Mr. Lamek as to any other incidents as you look

14

back over this time period. Any other incidents or

15

occurrences that were unusual that excited your

16

interest, your suspicion, or your concern. In fact

17

then you did go through and you outline this incident

18

with respect to what you had seen with the Lombardo

19

baby and it covered two or three pages. If I summarize

20

it for you, you can correct me if I am wrong. It

21

appeared to be that during the arrest somebody had

22

tested the potassium level of the child and had come

23

back and it was high, that was one factor that you

24

will recollect, am I right?

25

A. On the Lombardo child?

Q. Yes.







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C11

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A. Can I have the chart?

4

Q. Yes, all right, let's do it  
that way. It is Volume 106, page 4185.

5

MS. MCINTYRE: Did the witness ask  
for the chart or the transcript?

6

7

THE WITNESS: I would like to have  
the chart that way I can --

8

9

MR. SHANAHAN: Q. Could I review  
with you first what you said about it and I am going  
to try and convince you that it is Lombardo, if I can.  
Okay, if I could see what you said, and I refer you  
to Volume 106, page 4185, can I do that?

10

11

12

13

A. Page 4185?

14

Q. 4185 is Mr. Lamek's first  
question to you with respect to that, have you  
located 4185?

16

17

A. Yes, I have.

18

Q. All right. The question starts  
on line 6:

19

20

21

22

23

"With respect to any of the babies at  
whose arrest you were present, did  
you ever see anything that you regarded  
as unusual or that at the time excited  
your interest or suspicion or concern?"

24

And you said:

25





CC12

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"A. Yes."

And continuing on the next page, Mr. Lamek asked you:

"Q. Can you tell us about that event,  
or those events please?

A. I don't remember the child. I  
have looked at it and from looking at  
the chart and the time sheets I have  
narrowed it down to two children.

Q. Yes, who are they?

A. Lombardo and Gionas.

Q. Yes.

A. And it was during the arrest  
the potassium results came back and  
they were high, and the doctor ordered  
a plain bag of IV solution to be hung,  
and at the end of the arrest the  
doctor reached up and took the IV bag  
and put it into his pocket.

Q. The plain IV bag that he had  
ordered hung there?

A. No, the first bag that had been  
up there, he reached up and took that  
down and put it into his pocket."

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"Q. You don't know which child it was, are you able to tell us, if it were Gionas which physician it was; if were Lombardo which physician it was?

A. I could, but I can't be definite that it is one of those two children. I have narrowed it, it looks to me like it was one of those two, and then I would have to look at the charts to see which doctor it was.

Q. Did you make any comment or raise any question when you saw that occur?

A. Yes. I went over to him and asked him what he was doing.

Q. What did he say?

A. He was sending it down to the lab, he was looking for potassium.

Q. Is that what he said to you?

A. I either asked him if he was looking for a high potassium, or that is what he told me, I don't remember the exact conversation.

Q. What would a physician normally do if he wanted to send anything to the





1

2

"lab, whether it be the contents of an  
IV bag or anything else?

3

4

A. He would send it to the lab, send  
the bag to the lab for potassium.

5

6

MR. LAMEK: Q. I take it he would not  
normally put the object into his pocket?

7

8

A. That's right."

9

10

MR. SHANAHAN: Q. Now, those are the  
features that you mentioned there. It was during  
arrest of a child, a high potassium reading came back  
and the doctor took the bag as you described it and  
had it taken away for testing in the lab for potassium?

11

12

13

A. He took the bag down after the  
child had died.

14

15

16

17

Q. All right. Now, if you could,  
Mr. Elliot, provide her with the Lombardo charts,  
that is Exhibit 78. You may have them in front of  
you.

18

19

20

First of all, the terminal events on  
the Lombardo child are set out on page 41, if you can  
locate that, it is the medical resident's note. Do  
you have that page, ma'am?

21

22

A. Yes, I do.

23

24

25

Q. All right. And the mid right  
hand side there are a set of numbers and times, that







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2

will locate it a little bit better for you.

3

3:40 vomited and suctioned; 3:45 arrest.

4

So, that would seem to indicate the arrest commenced there. There are some more notations.

5

6

A. I'm sorry, would you start over again. This is page 41?

7

Q. 41.

8

A. Oh, okay, I'm with you now.

9

Q. Around the middle of the page.

10

A. Yes.

11

Q. Which indicates first of all that the arrest is started at 3:45?

12

A. Yes.

13

14

Q. All right. And then there is a notation about at 3:48 things being done and Dr. Rose and the parents being informed and then there are notations that at 4 o'clock, which would be 15 minutes into the arrest, approximately, there is a number or a lettering that is squared in black ink, it says "K7.4NH?

19

A. Yes.

20

21

Q. All right. And that would seem to indicate, I am suggesting to you, that in fact there were readings done and that the potassium came back in the midst of the arrest at 7.4?

22

23

24

25





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A. That's right.

3

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Q. All right, and Dr. Rowe has told us that he thought that was high. Do you know anything about the relative --

5

A. That's high.

6

7

8

9

10

Q. That's high, all right. Now then, if you could turn to page 19. This is really just a note that would seem to confirm it but we will get through it here quickly. Do you have that page, ma'am?

11

A. 19?

12

13

Q. Yes, and it is a note written by Dr. Halpern:

14

15

16

17

"Resuscitation was immediately started with cardiac massage, intubation and ventilation as well as medical treatment. About 10 minutes after the arrest the pH was 7.16,..."

18

19

And then it continues on with some other figures and I won't give them. The next sentence says:

20

21

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"Electrolytes from the same sample showed a sodium at 146, potassium at 7.4(not hemolyzed), ..." that seems again to tie into the timing after arrest, potassium level, which was what you were concerned about in





1

2

your baby?

3

A. Yes.

4

Q. And in fact that potassium level

5

being high?

6

A. Yes.

7

Q. All right. And one final

8

thing, ma'am. On page 102 of the documents you have  
in front of you are actual computerized results here,  
if you can turn to that page, ma'am, page 102.

10

A. Yes.

11

Q. Do you have that?

12

A. Yes.

13

Q. All right. Stephanie Lombardo

14

died on a long night shift that would have commenced  
on the 22nd of December and she would have died in  
the early hours of December 23rd. You can see in  
that second and last column there is a notation that  
on December 23rd with no time?

18

A. Yes.

19

Q. But certainly some results were

20

taken. Again, coming down that to the potassium  
reading is the 7.4 reading that we see now mentioned  
twice?

22

A. Yes.

23

Q. All right. I suggest to you,

24

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ma'am, that as between the two, Gionas and Lombardo,  
and bearing in mind what Mr. Labow has pointed out  
here about not being able to be assisted by who the  
other supervisor might be, that on those factors  
alone it really seems to be that the baby you made  
that observation of and the doctor's actions was in  
fact Baby Lombardo?

8

A. I can't be certain.

9

10

11

12

13

Q. I appreciate you can't be  
certain but I am suggesting to you that on the factors  
that you could remember about the child, potassium  
reading being high, it being taken during an arrest,  
those factors, that in fact Baby Lombardo fits that  
scenario?

14

15

A. Baby Gionas had a high potassium  
as well.

16

17

18

19

Q. But no suggestion that during  
the arrest and after the arrest point, during the  
resuscitation procedures that in fact Baby Gionas  
had a high potassium reading that any sample was even  
taken?

20

21

22

A. I would have to reflect or go  
over the chart. It seemed to me that Baby Gionas  
did have a high potassium level as well.

23

24

25

Q. All right. I am not saying





1  
2 the high potassium, I am saying that the actual event  
3 of taking a sample right after the arrest commenced,  
4 as we have here on Lombardo, and having that high  
5 reading during resuscitation, correct me if I am wrong,  
6 but I don't think Gionas had that after resuscitation  
7 started?

8 A. I would have to look at her  
9 chart to be sure.

10 Q. All right. Well then, you  
11 would agree that certainly Lombardo fits the  
12 description of the child and the events of that child's  
13 arrest as you set out for us here yesterday?

14 A. Oh, yes.

15 Q. All right, fair enough.

16 Now, the second time that Lombardo --  
17 Well, first of all before we leave that. You indicated  
18 that in fact the doctor's behaviour you felt was  
19 unusual, is that right? The doctor's behaviour  
20 in taking that IV bag and putting it in his pocket  
21 was unusual?

22 A. Yes.

23 Q. All right. It was unusual  
24 enough that in fact you spoke up and you asked him  
25 what he was doing?

A. Yes.





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Q. All right. Was there another nurse there as well I think and the two of you perhaps even mentioned, what is he doing?

5

A. Yes.

6

7

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9

Q. All right. I suggest to you as well that in fact one of the ways that he could have had that tested would be simply to ask you or any other nurse to take the bag and have it tested for high potassium, is that right?

10

A. Yes.

11

Q. Delegate it?

12

A. Yes.

13

14

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18

Q. And I suggest to you that one of the things that you are reacting to now and reacted to then was that in fact his taking of it himself displayed to you an obvious, if you like, confidence or trust in those other people that were there in the room and their taking it down to test it for potassium or whatever?

19

A. Would you repeat that, please.

20

21

22

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Q. His taking it himself and putting it in his pocket and not delegating that job to you or any other nurse that was there indicated to you then something surreptitious about what he was doing, that in fact perhaps he didn't trust those other





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individuals that were there to do that task?

3

4

A. I don't know what my exact thoughts were as to why he did it but it just didn't seem right he did it that way.

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Q. All right. Mr. Lamek used a number of terms: unusual, suspicious and concern. I am suggesting to you that in fact it was unusual enough that really it more than raised your interest, you felt that he had a concern about the cause of Lombardo's death and that that concern could be related to what was in that IV bag?

12

A. Yes.

13

14

15

16

17

18

Q. All right. And that concern then, to take it one step further, it would have been easy to say that right there Lombardo died from her anatomy, obviously therefore the problem heart, but this doctor obviously was concerned right there about something in that IV bag maybe having led to her death?

19

A. I would say so, yes.

20

21

Q. All right. Had you ever seen that done before by a doctor?

22

A. No.

23

24

25

Q. If he wanted it done, what would be the normal route? Would he give it to a nurse







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to do?

A. He would usually - I would assume that they would say send the IV bag to the lab.

Q. All right. And finally the manner in which he did it there, ma'am, I wasn't there, you were and saw it, was there anything --

THE COMMISSIONER: I am sorry, could I interrupt just for a moment. Just sending it to the lab is not by itself good enough, doesn't he have to say what it has to be tested for?

THE WITNESS: Well, send it down to see what the potassium level is or indicate specifically what he wanted done, yes.

THE COMMISSIONER: Yes, yes. Supposing he didn't want anybody to know, anybody present to know what he was testing for, would it not be reasonable for him to put it in his pocket and go and take it himself because he would have to tell, you can't just say test it because they will only test for what they are asked to test for.

THE WITNESS: You're right.

THE COMMISSIONER: If he wanted to keep it away from the people or wanted the bag tested for something, it might not be sinister, he might just think that something had happened, some error





1  
2 had occurred and there was too much potassium in the  
3 bag - there shouldn't be any potassium in the bag I  
4 suppose unless the child was on potassium.

5 THE WITNESS: That is a possibility  
6 that he would do it, it just seemed unusual.

7 MR. SHANAHAN: Q. All right. Finally,  
8 was there anything secretive about the way he did it.  
9 Was he trying to get that bag into his pocket and  
10 get out of the room without attracting any attention  
11 of those that might be around young Lombardo's bedside  
12 and you sort of caught him up on it and pulled him  
13 to attention on it.

14 A. The way I remember it is, I  
15 was facing the door and Miss James was standing in  
16 the doorway.

17 Q. Yes.

18 A. And this doctor was on the side  
19 of the crib closest to the door. The nurses that were  
20 in the room were close to the crash cart which was  
21 on the other side of the bed and he reached up and  
22 took the IV bag down and Miss James and I both saw  
23 him out of the corner of our eye and looked and  
24 wondered, what's he doing.

25 Q. Yes.

A. So, I went over and asked him





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what he was doing and he was all by himself on that  
side of the bed.

3

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Q. All right, a strange enough  
incident that you remembered it much later in the  
term of events that year and now some two to three  
years later still remember that incident clearly?

7

8

9

10

A. I remember it, yes.

11

12

13

Q. All right. One final thing.  
You say you don't remember the doctor, you say  
you remember he had a moustache?

14

15

16

17

A. Yes.

18

19

Q. Would you know what Dr. Halpern  
looked like?

20

21

22

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24

25

A. No, I don't know Dr. Halpern.

Q. You don't know him.

THE COMMISSIONER: You do not know him  
well enough to know that you have never met him, is  
that it?

THE WITNESS: Oh, I may have seen him  
but it seems to me, and I can only speak from --

THE COMMISSIONER: I guess you would  
have had to have seen him if you were at the, and you  
were at the Lombardo arrest.

THE WITNESS: Oh, yes, I was there.

THE COMMISSIONER: He no doubt was







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functioning there.

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THE WITNESS: He could have been there but it seemed to me that it was the doctor in charge of the arrest that did it and that's why I just can't put a face and a name together.

MR. SHANAHAN: Q. In other words, you may have dealt with Dr. Halpern but you have no recollection of the man and you wouldn't know him if you saw him?

A. That's right.

Q. All right. So, you can't even tell us whether he has a moustache?

A. I don't know what he looks like.

Q. You dealt with David Nelles the following night?

A. I met him on the stairs shortly after, that night, the next night.

Q. That's what assisted you a lot later in being sure that in fact Susan Nelles wasn't there the actual night of Lombardo's arrest?

A. Yes.

Q. All right. You know David Nelles to see?

A. Yes.





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Q. Does he have a moustache?

3

A. I think he had one then, yes.

4

Q. Was he there at Lombardo's

5

resuscitation?

6

A. No, he wasn't.

7

Q. No. You know him well enough

8

that you would recognize and remember him had he been  
there?

9

A. Oh, yes.

10

Q. Right, so, it's not him either?

11

A. No.

12

Q. Right. Now, is there anything

13

else about Lombardo's resuscitation that you

14

remember, anything else about the events surrounding

15

there that you can tell us about. And that is a

16

rather general question but it is simply that I've

17

got to rely on you to remember and describe it for  
me.

18

A. What night was that?

19

Q. December 23rd. Do you want

20

the page with respect to her terminal events, is

21

that what you're looking for?

22

A. No, I was going to look on

23

the tour end report to see if there is anything in  
here.

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Q. All right.

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A. That I recall, yes.

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A. Yes.

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Q. All right. You indicate that in fact names come forward, and one of the things that struck me here was, first of all, two names and only two names are bandied about by you and Lynn Johnstone, isn't that right?

A. Yes.





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Q. Right. Although other teams may have been there at the time, Bertha Bell's team specifically, and although some of the deaths may have occurred on 4B, which would be Bertha Bell's side, Bertha Bell's name or any of the nurses that worked with her didn't come up in this conversation?

A. That's right.

Q. All right. And with respect to those two nurses you indicated that you put forward it was Phyllis Trayner, Lynn Johnstone suggests Susan Nelles and you brought up that in fact it wasn't Nelles because Nelles hadn't been there for Lombardo?

A. That's right.

Q. All right. Well now, why would Lombardo out of all the babies that had died beyond the March rush of deaths there, as you went back over the months, right back into July when there was a cluster that you have remarked upon and thought, my goodness, here's a pattern here, why was it that out of all of those deaths Lombardo sprung to mind?

A. I don't know.

- - - -







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Q. You will agree that with respect to deaths that occurred, there were others where Susan Nelles was not present as well?

A. That's right.

Q. Could I suggest to you, Ma'am, in fact not only was there that unusual incident that you have recounted for us but that in fact there was at and around and after the death of Lombardo concern expressed by people to nurses and the doctors that were there about the suddenness and the unexpected nature of her death?

A. I don't remember.

Q. Could I suggest to you that in fact of all the deaths over that time period there was not only the incident that you recounted with respect to the doctor, and that incident really didn't come up between you and Lynn Johnstone (you were talking to Lynn Johnstone about the IV bag)?

A. No.

Q. No. So that would not distinguish Lombardo in terms of that conversation.

I am suggesting to you what distinguished Lombardo was your own perception and that of others that you knew about that Lombardo's death was sudden, unexpected and sort of inexplicable, if you like, given her stability prior to her arrest?





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A. That could be. I can't say  
for sure.

Q. You will agree with me in  
retrospect of the 36 deaths given the cluster that  
had just happened - or it is somewhere less than 36  
to be fair - to look back over the previous 8 months  
somewhere around 30 deaths, to pick out Lombardo is  
rather, as you look back now, is rather surprising?

A. I agree.

Q. All right. And you will  
agree that although you may not know the present  
reason, you can't give it to me clearly, there must  
have been some reason in your mind why you would  
spring up and say, "Just a minute now. It couldn't  
have been Nelles because after all she wasn't there  
for a death, and that death was Lombardo."

It is unusual that you would zero in  
on one death such as that?

A. I don't know what was going  
through my mind.

Q. Ma'am, with respect to  
certain of the instances that happened over the  
months, you indicated, and I if I just summarized it it  
will probably go a lot quicker, I don't think there  
was much contention.





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You distinguished a pattern by the end of July. You saw the features, that is the isolation on a certain ward, the isolation of a certain team and the timing of them in the middle of the night.

A. Yes.

Q. You indicated that in fact as you went about on the rest of your rounds that other staff were commenting on the rising number of deaths up there.

A. Yes.

Q. And I suggest to you that it was quite obvious from their comments that they too were perceiving those common factors that you had outlined?

A. Yes.

Q. In fact Mr. Roland alluded to this earlier about you hadn't distinguished, you and Nurse Johnstone in that conversation didn't distinguish between 4A and 4B. I am suggesting to you when you went around on your tour and you got this kind of response, "Well, we heard there was a Code 25 up there. Did the baby die? Yes, it died. Was the same team on?", in fact, they too never distinguished between 4A and 4B.

A. That is right.







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Q. They asked about a certain team and they named that team in the name of the team leader, Phyllis Trayner?

A. I don't know whether they named --

Q. Did they not say to you, "Was the Trayner team on again?"

A. I can't say for sure.

Q. All right. You said you eliminated certain things in your mind. You said you thought it was the Pacsai incident. You spoke to Schaffer, Dr. Schaffer and Dr. Costigan, and they took your comments and mentioned about an intermediate ICU. They said they were looking into it as well or it was being looked into.

A. That had all taken place, yes.

Q. Schaffer and Costigan never put to you that an adequate explanation for the rise in deaths here was the anatomical problems? That didn't come up from Schaffer and Costigan to you, did it?

A. Would you say that again, please?

Q. When you discussed it with Schaffer and Costigan, they said to you it was being





EE5

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looked into; people were aware of it?

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A. Meaning the baby deaths?

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Q. That is right.

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A. Yes.

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Q. But nowhere do they suggest to you, put your mind at ease; the care you are giving is fine. In any event, they are so ill with their anatomical problems, that is probably the cause?

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You haven't suggested Costigan and Schaffer said that to you as an explanation for that large cluster of deaths?

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A. I haven't said that, no.

12

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Q. No, and they didn't in fact say that to you to the best of your recollection?

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A. Not from what I remember.

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Q. All right.  
Now you said that -- part of your response was you made your rounds there first and you would pop back a couple of times during the night.

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A. If I could, yes.

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Q. You also said, though, you felt they were getting good care; you didn't feel the nurses were missing anything nor were they failing to notice anything or to respond in time.

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A. That is correct.

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Q. Well then if you were popping back, having eliminated a run of bad luck or just sheer coincidence, being sure they were getting good care and timely response, I would suggest to you the fact that you started to go back there more, return earlier, return more often, is the fact that you perhaps perceive or feel then that the cause of this problem is perhaps in the personnel, in the staff. It is a manmade problem. And by you being back there, and if you like policing the ward a little better, if it is a certain laxness or carelessness or even deliberate, you may be able to do something about it?

A. I can't say that, no.

Q. All right. You can't say that but you will agree just in analyzing what you did and perceived, you didn't perceive any decline in nursing care or their response?

A. That is right.

Q. All right. And yet you did continue to return there as if you returning there could in some way solve this rise of deaths?

A. No, I don't think I was there to solve.

Q. All right. Your presence





Coulson  
cr.ex. (Shanahan)

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EE7 2 might stem this tide of deaths?  
3 A. No.  
4 Q. Why were you going back?  
5 A. I was going back -- I would  
6 go back to see if there were any problems, just to  
7 have a look but not -- it would be more for my own  
8 personal sense of concern if I had any concern, but  
9 this was not something I did every single night,  
10 every night that I was on I didn't pop back three  
11 and four times. But if I did have time, I would pop  
12 back, but it wasn't a deliberate concentrated effort.  
13 Q. All right. So you will  
14 agree that you went back and as you did go back you  
15 never felt there was a decline in care, but you would  
16 resist the suggestion that in fact you were going back  
17 to in any way police the ward?  
18 A. I was not going back to  
19 police the ward, no.  
20 Q. All right. And then finally  
21 it got so bad that you said that at times when you  
22 got the Code 25s you would go back to the floor and  
23 you wouldn't even know which baby it could be that  
24 was arresting?  
25 A. Sometimes when the Code would  
go --







EE8

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Q. Yes.

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A. -- I wouldn't know who had

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arrested.

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Q. And you said you started,

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and others have remarked on this, the previous witness  
here, that in fact you started to watch the clock.

7

A. Yes.

8

Q. And that is especially

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that time frame that Mr. Hunt pointed out yesterday?

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A. Yes.

11

Q. You really get to the point

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where in spite of you going back and popping in there

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early and popping in there additional times that

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really you can't get to the bottom of this cluster

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either in June or July, in January, December or in

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March?

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A. That is right.

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THE COMMISSIONER: Mr. Shanahan, I

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don't know whether you are familiar with the change in

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the procedure.

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MR. SHANAHAN: I won't be long but

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I will be long enough...

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THE COMMISSIONER: All right. We

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will take 20 minutes.

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--- recess.

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EE9

--- on resuming.

THE COMMISSIONER: Yes, Mr. Shanahan.

MR. SHANAHAN: Thank you, sir.

Q. Miss Coulson, had you known Phyllis Trayner prior to the start of what we are referring to as the epidemic period? That is prior to the end of June, start of July of that year.

A. I don't remember exactly when I met her but it was before 4A/B. I knew her on 5A.

Q. All right. Can you put a time frame on that as to how long you might have known her? In the Hospital as a nurse.

A. Not for long. I didn't know her very well.

Q. So in terms of the traits that you might have seen and that you have commented on here, the traits that I think others, Mr. Percival and Mr. Hunt have put to you that others saw in her and asked you if you as well saw those traits, as to whether they existed before what we now call the epidemic period or whether in fact they really came to the fore around the commencement of the epidemic period, I take it that your answer would be you really didn't know her well enough prior to the epidemic period to be able to comment?





Coulson  
cr.ex. (Shanahan)

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EE10

A. I agree, I couldn't comment.

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Q. All right. You said to

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Mr. Hunt this morning with respect to Nurse Browne's

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position that if in fact there was an overdose of

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digoxin and if in fact that had caused a death you

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would accept the proposition that it would be a nurse

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if in fact there were a great enough or significant

enough number of deaths?

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A. What he said this morning?

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Q. Yes. Do you remember that

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evidence?

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A. Yes.

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Q. I would suggest to you that

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clearly the number of deaths in March, and I am just

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looking at the three clusters if you like, and I am

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omitting for the moment ones in between, but that

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group in March, the group in December and the group

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in the previous June-July, in fact there is enough

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of them there that clearly if they were caused by

an overdose of digoxin, that in fact comes down to a

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nurse having done it?

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A. If it was all of them, and

we are talking about thirty-some children --

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Q. No, not even just 30.

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I am suggesting to you there was

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EE11 enough in March, joined with the group in December,  
joined with the group in June-July (specifically  
July), that group alone, there is a significant enough  
number there that if in fact it was felt that their  
deaths were caused by an overdose of digoxin, that  
large number really leaves no other option but that  
it must have been a nurse?

A. I can't comment on that one.

Q. All right. You said to him  
if there was a significant number -- one or two  
deaths you wouldn't necessarily say it was a nurse;  
someone else I take it could have snuck in there and  
have done some harm, but a great enough number and  
you would come to the conclusion, given the standard  
of care and how often the nurses are around and how  
easily someone else would be suspected, that in fact  
at some point in time you would agree it would have to  
be a nurse giving these overdoses. What would that  
number be then?

A. The only thing that comes to  
my mind is a collective number, and the collective  
number I am referring to that I had referred to you  
before was 25 or 30 deaths.

Q. All right. And the clusters  
then in March, December and July you don't find that





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grouping significant enough in your mind to say it must  
be a nurse as opposed to someone else?

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A. I wouldn't say it must be  
a nurse.

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Q. All right.

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Finally, ma'am, with respect to the  
aspects of this, and I am accepting -- I am asking  
you for a moment to look if you like from a cynical  
point of view here - if in fact digoxin overdoses  
were being given to these children, you will agree,  
first of all, in terms of the time of the likely  
administration and the onset of the symptoms and the  
death, that would have occurred at perhaps the  
quietest time in the 24-hour period in the Hospital?

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A. What would have occurred, the  
giving of --

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Q. The giving, the onset of  
symptoms and then the death in that period of one  
o'clock, two o'clock, three o'clock, four o'clock.

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I put to you that that must be the  
quietest time in the Hospital over a 24-hour period.

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A. Not necessarily.

Q. All right. In terms of  
busyness and in terms of the number of people that  
are around, perhaps "quiet" isn't the thing, especially





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on a children's ward, but in terms of number of  
people.

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A. Numbers of people, yes.

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Q. It would be --

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A. There are less people around  
during the night than there are during the day.

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Q. And this would be not just  
at the start of a shift when there might be some  
crossover of time; this is well into the shift around  
two and three o'clock in the morning when any lingering  
people from that evening part would be gone?

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A. That is right.

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Q. In terms of the victims here,  
you will agree that there is a significant difference  
here between overdoses perhaps being given to an  
adult population who might in fact have other adult  
patients with them who could observe what a nurse was  
doing. The very person who was given the dose if they  
survived it could even in fact give some later  
evidence or testimony.

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You were dealing here with children  
exclusively on 4A and 4B.

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A. Yes.

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Q. You were dealing with the  
drug that we suspect here was readily available and

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certainly wasn't inventoried at any time before or  
3 at the end of a shift of nurses.

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A. That is correct. Are we  
5 referring to digoxin?

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Q. Yes.

7

A. Okay.

8

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Q. You are dealing with nurses  
8 who would obviously know how to use digoxin and how  
9 to administer it.

10

A. Yes.

11

12

Q. And who if seen with a  
11 syringe or digoxin ampoules would not immediately be  
12 the object of any suspicion.

13

A. Would you say that again.

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Q. If seen with a syringe and  
14 an ampoule of digoxin (that is a nurse) would not  
15 be the object of any suspicion.

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A. Usually a nurse does not  
17 give IV digoxin.

19

Q. What I am saying --

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A. And that would be in the  
20 ampoule.

21

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Q. But simply seen with it,  
21 would not be the object of any suspicion.

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A. If there wasn't a doctor







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around, it would be unusual I would think.

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Q. Others have said that it was common knowledge that there was no routine post mortem testing for digoxin. Did you know that?

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A. That there was no...?

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Q. Routine post mortem testing for digoxin.

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A. I think I was aware of it, yes.

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Q. And finally we have heard that clinical observations with respect to digoxin and its effects were very important, Dr. Rowe said. He felt as important as the actual blood readings and that staff would know the symptoms at the start of the onset of toxic symptoms of digoxin, would be trained to look out for that and would be aware of that.

15

A. Who are you referring to?

16

Q. I am referring to nurses.

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A cardiology nurse, Radjojewski, Bell, Trayner, Nelles, working in there would know what to look for and what would be displayed by an overdose of digoxin.

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A. I would assume they would know what the signs, the signs of digoxin overdose were, yes.

Q. Then getting down to this proposition with respect to someone having the where-withall, or the brains, or the sophistication to implement this; with respect, ma'am, it would strike me that a trained competent nurse who had enough expertise to be part of a cardiology team, let alone perhaps to be the leader of that cardiology team, had all the tools at her disposal to implement this, and that in fact she was dealing with a captive audience, an audience that could never come back even if they survived the attack, they could never come back to give any evidence against her, and that it didn't require a very sophisticated scheme at all, or much brains to do that?

A. I can't comment on that.

Q. Do you know the Estrella history?

A. I know she was a sick child when she was admitted.

Q. I am sorry to interrupt you.

A. I know she had been up on 7C/D and back to 4A.

Q. Did you know the last few days





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the rise and fall of her digoxin levels?

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A. I was aware that there was

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trouble regulating Janice's digoxin level.

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Q. Trouble regulating it; it got

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high, it got low?

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A. Yes.

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Q. You knew then that she died

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and subsequently somewhere way down the line you knew  
she had an extremely high reading, months later?

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A. Subsequently, yes, later.

11

Q. Did you know about perhaps the

12

attendance of Phyllis Trayner with respect to the  
timing of these high readings?

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A. No.

14

Q. Whether she was on or off?

15

A. No.

16

Q. You will agree that if you want

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to look at Estrella in a certain light with respect

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to the sophistication of any scheme or plan, that in

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fact Estrella may well stand for the proposition that

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if at first you don't succeed in terms of these high

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doses there is certainly no one around to prevent you  
trying again?

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A. I don't understand what you are

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saying?

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Q. What I am suggesting to you in fact is this scheme is so simple that if in fact the first overdose of digoxin doesn't do it there really were not the constraints there, either in the dispensation of the drug, or in the patient itself that was being dealt with, to prevent a second attempt being made with no one else being the wiser?

A. I can't comment on that.

MR. SHANAHAN: Thank you.

THE COMMISSIONER: Mr. Tobias.

CROSS-EXAMINATION BY MR. TOBIAS:

Q. Miss Coulson, my name is Warren Tobias and I act for the family of Jordan Hines. In some quarters it is said that they save the best for last, but I give you my personal assurance that is not the case here.

We have had some discussion both in your examination in chief, and in particular in cross-examination by Mr. Labow, regarding the tour end reports.

A. Yes.

Q. And just so that I can understand your evidence; I took you to be saying that it was not necessarily those children who were the most seriously ill who would be mentioned on that tour end





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report; do I have that correctly?

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A. Other children could be mentioned

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as well.

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Q. And in particular would it be

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normal, or usual, if there were a new admission on

7

the ward during their particular shift, for there to

8

be a note of that on the tour end report?

9

A. If a child came in during the

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evening usually the supervisor would write the child's  
name down.

11

Q. And I take it that would be

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because on your shift, if the child were admitted

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late enough in the evening when you came on at eleven

14

it would really be your shift which would be the first

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full shift for which the child was in the Hospital

16

and you would need some information regarding the

17

A. Yes.

18

Q. Now, are there any other

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circumstances, other than the circumstances where a

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child is very seriously ill, or where he or she is

21

a new admission, where their name would appear on the

22

tour end chart?

23

A. Yes. If the child's condition

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had changed; if the child was going off for a special

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FF.5

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test, or surgery; if a child had been transferred to Intensive Care or from Intensive Care, or perhaps to another floor.

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Q Is it also fair to say this, if a child had a condition that was potentially life threatening, potentially a very grave situation, that that might be noted on the tour end report, even if the child was stable at that particular time, because a child with that condition would bear a certain amount of extra watching, is that a likely possibility?

11

A It could happen.

12

13

Q With respect to the tour end charts I believe you have them before you?

14

A Yes.

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Q Since we only have one copy I would like to ask you some questions regarding them, and I will ask them from up here with your permission so you can examine the document as well.

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Do I take it that the comments that are noted on the tour end report would be a comment pertaining to the observation of that child over a given period of time, rather than at any one given point in time?

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A It would depend on whose writing it is. Do you want me to be a little more specific?







FF.6

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Q. Please.

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A. The person who has put the child's name, say it was the child's nurse during the day shift, she would put down what she felt was pertinent; whether it was at the time or in summary. The same with the evening supervisor, she might make a comment earlier on during the night, later on, and perhaps no comment, maybe make a mark, because the sheet is a worksheet, and the same with the night supervisor.

Q. Let me ask this specifically. If I were one of the supervisors and at the end of my shift I wanted to report to you that over the course of my shift, over the last eight hours a child's condition had stabilized, the child was now stable, and you saw the comment "stable", would you take that to mean that that child had been stable over the course of that shift, or over the majority of that shift, or just that that was my very last observation for that child before I went off?

A. That would be the last observation, because if you had seen the child you would have made another comment.

Q. Fine. If the child had run say a high fever --







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A. Yes.

Q. -- and I wrote on the chart "no fever", would that indicate to you that there had been no fever present during the entire course of my shift?

A. I would assume that from the last observation that you had --

Q. Yes.

A. -- that is what it was when you saw it.

Q. And if I were concerned let's say about arrhythmias in particular, and you saw a comment on the chart "no arrhythmias", would that indicate that over the course of that entire shift no evidence of arrhythmia had been seen, because obviously if some had been seen, even though I hadn't seen it the last time I checked the monitor that is something I would want you to know?

A. If you had concern that there was arrhythmia you would mark it down so I, coming on, would know that.

Q. Exactly, so if I wrote the comment that there had been no arrhythmias exhibited at all, you would take it that during the course of my shift I had no information that the child had suffered any arrhythmias?





FF.8

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A. That's right.

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A. Where do you see that?

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Q. Under Admission date in the top right-hand corner "Admission date March 6, 1981".

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A. Yes.

13

Q. Fine.

14

A. Where do you see the time?

15

Q. The time 00.40.

16

A. Oh, there.

17

18

Q. So can we agree that he was admitted some time after midnight starting on the 6th of March, or so it would appear from that?

19

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A. That is from the admission and discharge sheet but that doesn't necessarily mean that's the time the child came in.

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Q. No. In fact the child may have come to the Hospital earlier, it is my information that he was seen in Emergency prior to being admitted.





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A. From my knowledge of it I would assume that is when this paper was filled out.

Q. Now, with respect to the tour end reports, there is a report, and this is at page 128, Mr. Commissioner.

MR. ROLAND: Mr. Commissioner, I don't think you have a copy of the tour end report and I will let you use mine.

THE COMMISSIONER: Oh, I see. Thank you, Mr. Roland.

MR. TOBIAS: Thank you, Mr. Roland, I appreciate that.

Q. That would appear to bear the date March the 5th, 1981 and it is for Ward 4A, am I correct?

A. Yes.

Q. And I notice that on the back of that page there is a note: "Admission Jordan Hines". Now, I take it one of the reasons why it was noted on the tour end report that day was because he was a new admission?

A. He was coming in, yes.

Q. And at page 66 of his medical record there appears to be a note 5.3.81, admitted 24.30 and there has been some confusion in the past







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as to what that means. Was that in fact 12:30 on the 6th that he actually reached the ward, or was it the 5th?

My point is simply this, can we agree that it would appear that when he was admitted was some time either on the 5th or 6th and the first note you see on the tour end reports is a note of his admission.

A. The only indication that I would have here, there is no note here as to whether the child actually came in, there is nothing written down here.

Q. Okay.

A. So I would assume from that if the child did come in his condition, did not warrant a note.

Q. My point is that the notation "new admission" does not indicate to you that that child was noted as being critically ill?

A. That's right.

Q. Okay, that is that page, all right. Now, are you aware basically of what the condition of Jordan Hines was when he was admitted, are you familiar with his medical record?

A. No, I am not.





FF.11

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Q. Do you know, or have you heard that one of the things he was being monitored for was apneic attacks?

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A. I know that from his chart.

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Q. And you also know that he was suffering from brady/tachycardic episodes?

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A. Yes.

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9

Q. And his heart rate had changed dramatically?

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A. Yes.

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Q. Now, I would like you to go with me if you will to page 129 of the report, and that bears the date of MarCh 6th, 1981. On the back there is a note again on Jordan Hines. If I can just read to you, it says, down at the bottom right-hand side of the report:

16

17

"One apneic episode no colour change, one bradycardic."

18

19

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Q. Do I understand that what is indicated there is that at least one apneic episode was observed on that shift?

21

A. That is what the supervisor has written down.

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Q. That is what the supervisor is trying to indicate, do I have that correct?





FF.12

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A. That is what she has picked up.

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Q. What is the significance of

4

there being no colour change, is that some sort of

5

indication of the degree of severity of the apneic

6

spell?

7

A. Yes.

8

Q. If the child did become cyanotic

9

and change colour, I take it that would be a more

10

extreme apneic spell than one where there was no

11

colour change and you would be more concerned about

that?

12

A. Yes.

13

Q. Do I have that correct as well?

14

A. Yes.

15

Q. All right. If you will also go

16

with me to page 130 which is the tour end report for

17

March the 7th of 1981, and again on the back there

18

is another notation with respect to Jordan Hines,

whose handwriting is that?

19

A. This one here?

20

Q. Yes.

21

A. I don't know.

22

Q. I think you gave evidence earlier

regarding the word "stable" in checkmarks?

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A. That's mine.

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FF.13

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Q. Does that indicate to you that on that shift at least Jordan Hines was stable, his condition was not critical?

A. When I saw that child he was stable.

Q. And do you also agree with me that in fact this report indicates, and this is in the first line, Mr. Commissioner:

"No apneic episodes. Remains on apneic and cardiac monitor."

Do I have that correctly?

A. Yes.

Q. And then about the second line from the bottom:

"No apneic episodes noted."

A. That's right.

Q. So that at least at that time the supervisor was indicating that the child was in stable condition, and you confirm that you saw the child five or six hours before he was pronounced dead and the child was in stable condition, and at least on that shift there was no evidence of apneic attacks noted, do I have that correctly?

A. From the tour end report, yes.

Q. From the information on the tour end sheets?







FF.14

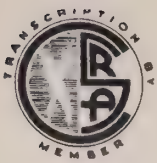
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A. Yes.

Q. Now, indeed I have had an opportunity as well to review the progress notes on the chart. Mr. Registrar, just in case there is a request by Miss McIntyre perhaps you should put Exhibit 103 before the witness.

Now, if you could turn to page 67, there is a progress note by Registered Nursing Assistant Brownless, dated March 7th, 1981, and the time period appears to be 1530 hours to 1915 hours.





G/BM/ak

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2  
3 You can either read the note to  
4 satisfy yourself or take it on face that I don't  
5 see any reference in that note whatsoever to any  
6 apneic episodes. My question to you is this.  
7 Obviously if you were watching for apnea and the  
8 child were on an apnea monitor the absence of  
9 seeing an apneic episode obviously is a good sign.

10 A. That is right.

11 Q. And to that extent it jives  
12 with and is consistent with the comments that the  
13 child was stable on the 7th.

14 A. Yes.

15 Q. There is no inconsistency  
16 there at all. Indeed, the only evidence that we  
17 then see, and this appears at page 68 of the chart,  
18 afterwards was that the apnea monitor went off at  
19 around 4:10 after the cardiac monitor went off and  
20 that appears in the progress note of Meredith Frise.

21 Now, again, my point is this. The  
22 absence of any apnea attacks during the course of  
23 Miss Reaper's shift, the long night nursing shift  
24 again is the positive sign, is it not, and jives  
25 again with the observation on the tour end sheet that  
the child was stable. Do I have that correctly?

A. I'm just going to read it over.





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Q. Okay, fine.

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A. Up until 4:10 Susan Reaper says from her notes, it looks as if the child was, yes, stable.

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Q. Fine. Again, the point is that it is a good sign in a child that is being monitored for apnea and is consistent with the observation that his condition was stable.

10

A. Yes.

11

Q. Would you agree with that?

12

A. Yes.

13

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Q. Okay, fine. Now, I take it that in addition to all of that information, which is available to you in documents, you have your own recollection of having seen that child when you began your shift on March 7th, 1981.

17

18

A. I saw the child when he was stable.

19

20

21

22

Q. Your evidence was that he was stable. And is that why you were somewhat surprised, while you didn't expect that when the Code 25 was called that it would be Jordan Hines' arrest that you were responding to?

23

A. That's right.

24

Q. It must have been somewhat

25







1  
2 shocking at the time, was it not?

3 A. It was a surprise, yes.

4 Q. And following the arrest did  
5 you make any enquiries yourself of any of the  
6 cardiologists as to the cause of death with respect  
7 to Jordan Hines?

8 A. I don't remember.

9 Q. Okay. Do you recall receiving,  
10 whether you enquired or not, do you recall receiving  
11 any information thereafter regarding the cause of  
12 death of Jordan Hines?

13 A. Again, I don't remember.

14 Q. Okay. Do you today know what  
15 information is available regarding the cause of death  
16 of Jordan Hines?

17 A. I've read his chart but I can't  
18 remember exactly what was on it.

19 Q. Do you recall - let me ask the  
20 question specifically - do you recall hearing at  
21 any time between March 8th, 1981 and today the  
22 explanation being put forward that the child succumbed  
23 to Sudden Infant Death Syndrome?

24 A. I've heard that.

25 Q. All right. Now, I trust that  
I already can anticipate your answer but I'm going to





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ask the question anyway. Do you have any recollection as to whom you heard it from or when you heard it?

A. I know I read it in the chart.

Q. Okay. You haven't discussed I take it with any of the doctors at the Hospital or any of the pathologists?

A. Oh, no.

Q. So, you obviously can't give us any information?

A. No.

Q. Now, when you first read it in the chart - when would that have been? Do you recall when you would have first noted that in the chart?

A. When I was reading the charts before I...

Q. I'm sorry, before...?

A. Before my testimony I have gone through the charts.

Q. Before your testimony here?

A. Yes.

Q. So I take it quite recently you came across that piece of evidence?

A. Around Christmas time.

Q. Did it cause you any surprise?





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What was your reaction when you read it in the chart?

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A. There were some other comments

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I believe made.

5

Q. Well, let me assist you. There

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is a reference in the chart at page 29, this is the

7

preliminary autopsy report. I don't propose to

8

read it to you but perhaps if you could read the last  
two paragraphs to yourself.

9

A. It says it makes the diagnosis

10

of a missed-SIDS a possibility.

11

Q. Yes.

12

A. It does not explain the

13

arrhythmias or further conclusions... There is no  
evidence of an infraction.

14

Q. All right, I'm aware of what

15

it says and probably at this point so is the

16

Commissioner. But my question to you is this. Am

17

I correct first of all in suggesting to you that it

18

was that reference in the chart that you saw that

19

first made you aware of the Sudden Infant Death

20

Syndrome possibility? Is that what you meant before

21

when you said I found out about it when I was reading  
the chart?

22

A. Yes.

23

Q. Okay. All I want is your

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1  
2 reaction to that. Were you surprised, were you  
3 shocked, did you have any reaction at all?

4 A. I was somewhat surprised.

5 Q. All right. Now, I take it  
6 that you have been in nursing for how many years?

7 A. 14.

8 Q. I'm sorry?

9 A. 14 or 15; 14 I believe.

10 Q. Do you have any personal  
11 experience over the course of that 14 years with  
12 any children who succumbed to Sudden Infant Death  
13 Syndrome whilst in the Hospital? I'm not asking  
14 you about episodes you may have heard of, do you have  
15 any personal exposure or any personal experience?  
16 Have you ever seen that in your 14-year career?

17 A. I have cared for children with  
18 aborted SIDS.

19 Q. All right. In the Hospital?

20 A. In the Hospital.

21 Q. Right. Since you used the  
22 word aborted, I take it that those particular  
23 children did not ultimately succumb to SIDS?

24 A. They were resuscitated.

25 Q. All right, fine.

THE COMMISSIONER: I must say







1  
2 something very funny has happened to the "abortion",  
3 this is the saving of the child's life.

4 THE WITNESS: Yes.

5 MR. TOBIAS: It's a good thing  
6 that Mr. Manning isn't here, Mr. Commissioner.

7 THE COMMISSIONER: Yes.

8 MR. TOBIAS: Q. All right, my  
9 question was, can you recall an incident over that  
10 14-year span wherein the Hospital - have you had any  
11 personal experience with a child that succumbed to  
Sudden Infant Death Syndrome?

12 A. Not a personal experience.

13 Q. Okay. And if I were to put  
14 it to you that the literature on the subject indicates  
15 that the vast majority of SIDS deaths occur at home  
16 is that a proposition that you would quarrel with?

17 A. I've read that.

18 Q. Okay, fine. Now, with respect  
19 to this child's course in the Hosiptal, we know from  
20 the chart, and I believe you have direct evidence  
21 on this point, that the child was on an apnea and  
a cardiac monitor. Do I have that correctly?

22 A. Yes.

23 Q. Isn't the whole purpose of  
24 monitoring an infant in a hospital setting to in  
25





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3 effect serve as an early warning system so that if a  
4 child does get into trouble steps can be undertaken  
5 immediately to intervene and in effect prevent a  
6 terminal event from occurring. Isn't that the whole  
purpose of monitoring?

7 A. The alarm goes off when the  
8 child gets into trouble, yes.

9 Q. All right. In fact, that's  
10 why monitors were developed?

11 A. Yes.

12 Q. And I take it that there has  
13 been some fair degree of success with this technique  
in terms of preventing terminal events from occurring?

14 A. Yes.

15 Q. Okay, fine. Now, Mr. Shinehoft  
16 before was asking you about the administration of  
17 drugs, and I certainly don't want to get into the  
18 never never land that he got into, so, I don't think  
19 I will use a and b and I don't think I will use x and y,  
20 I will try and make the question as simple as I can.  
21 I understood your evidence to be, and please correct  
22 me if I have this wrong, that occasionally a nurse  
23 will give a drug which was supposed to have been  
24 given by another nurse and yet that nurse, all right,  
25 the nurse who was supposed to have given the drug





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3 in the first place will still sign for the administra-  
4 tion even though she didn't give it, and I understood  
5 your evidence to be that that is not supposed to  
6 happen but occassionaly it does.

7 A . That's right.

8 Q . Did I have that correctly,  
9 have I understood your evidence?

10 A. Yes.

11 Q. All right. I want to know  
12 whether this ever happens, whether you have any  
13 knowledge of it happening even occasionally. Could  
14 it happen that the nurse who gives the drug, although  
15 another nurse was supposed to give it, would sign in  
16 the name of not herself but the nurse who was supposed  
17 to have given it. Does that happen?

18 A. Not to my knowledge.

19 Q. Okay, fine. And that would  
20 be quite unusual and if that were caught, if that  
21 came to your attention, I take it that would be a  
22 major transgression?

23 A. Yes.

24 Q. Okay, fine.

25 THE COMMISSIONER: This is a nurse  
who - I'm back with Mr. Shinehoft, I'm a little lost.  
Is this the nurse who...







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3 MR. TOBIAS: If I give a drug that  
4 you were supposed to have given.

5 THE COMMISSIONER: Yes.

6 MR. TOBIAS: And sign your name,  
7 and I don't see per or anything, I just sign  
8 Mr. Justice Grange, that's what I'm asking about,  
9 whether that ever happens, and I believe Miss Coulson  
10 is saying no that doesn't or shouldn't, it is a  
11 major transgression if it does happen.

12 THE WITNESS: It would depend on  
13 the context. If I gave - if a doctor gave a drug  
14 and I signed for it I could put given by Dr. so and so  
15 but if a nurse gave it, if it was Nurse A I would not  
16 sign Nurse A.

17 MR. TOBIAS: Q. Having given it  
18 yourself.

19 A. Having given it myself, I would  
20 not put her signature.

21 Q. All right. Now, one thing  
22 that I don't understand, and I don't want to dwell  
23 on the point, but if one scenario can happen, that  
24 is, the scenario you have already put to us that  
25 occasionally happens, I don't understand why it's  
not equally possible that my scenario couldn't happen.  
If someone signs their own name not having given the





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drug then why wouldn't that same someone perhaps  
sign someone else's name, that person supposed to have  
been the one who has given the drug, what's so  
outrageous about that?

MR. BROWN: Is there a factual  
underpinning to this hypothetical?

THE COMMISSIONER: Well, I think it  
is certainly pretty hypothetical because I don't  
think anyone has ever suggested -- the one matter  
that we are worried about is the one signed by  
Susan Nelles and I don't think anybody has suggested  
that's not her signature. But you may have something,  
Mr. Tobias, we don't know anything about.

MR. TOBIAS: Well, I put to you that  
there is no factual basis, it is completely hypo-  
thetical, but I also put to you in fairness that I  
really take it that the entire topic has been treated  
hypothetically by every counsel, I don't think I'm  
pulling any new tricks out of the hat.

THE COMMISSIONER: Well, you may  
treat it hypothetically but I've got a particular  
instance in my mind when I ask about it.

MR. TOBIAS: Well, perhaps I should  
have let you ask the question then, Mr. Commissioner.

THE COMMISSIONER: I tried.





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MR. TOBIAS: I should just have passed you up a note.

Q. In any event, if I can be permitted just to pursue it thus far. What I don't understand is what the difference between the two situations are and I am trying very hard to understand that.

THE COMMISSIONER: Well, one of them of course is pretty close to forgery.

MR. TOBIAS: Yes, yes.

THE COMMISSIONER: The one you are suggesting.

MR. TOBIAS: Yes.

THE COMMISSIONER: If it's not forgery I would suggest, and the other one I take it is a pretty poor practice.

MR. TOBIAS: The other one is pretty close to falsification of records. I mean, I don't want to characterize the --

THE COMMISSIONER: I would have thought it is unprofessional but I think the evidence has been that it is unprofessional but I don't know that you could get away with any kind of prosecution under the Criminal Code. Maybe it wouldn't in this instance either, maybe it has to be a cheque,







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I don't know.

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MR. ROLAND: Mr. Commissioner, just to put this in proper context. The other factor we know is that during a resuscitation there is someone giving drugs and someone else writing out the drugs and so on, it's not the same person that's giving them that is recording them. That happens from time to time but that's in a different context.

THE COMMISSIONER: Yes, I understand.

MR. TOBIAS: And that's not the context that I was referring to. I am grateful to Mr. Roland for raising the point.

THE COMMISSIONER: The only one that I am concerned about, at least the only one that I have understood so far, is the one instance of the antibiotic in the case of Allana Miller.

MR. TOBIAS: Well, can we leave it here, sir.

Q. Your evidence, Miss Coulson, is that the scenario which I put to you, which is almost tantamount to a forgery as far as you are concerned and given your state of knowledge it's just not likely to happen. You have no knowledge that anything like that has ever happened.

A. I have never seen it happen, no.







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Q. Fine. Now, you also indicated with respect to the Hines resuscitation effort you were personally present on that occasion?

A. Yes.

Q. Do I have that correctly?

A. Yes.

Q. And in his discussion with you yesterday of the events that transpired during that resuscitation effort with respect to Nurses Trayner and Nelles, I noted with some interest that Mr. Brown had indicated at several places in the transcript, he kept referring to a discussion. Do you recall that, a discussion between Susan Nelles and Phyllis Trayner regarding the pacemaker?

A. Yes.

Q. All right. Now, I want to be clear here and I want to be fair to you, I want to give you a chance to use your own words, is it fair to say that what went on during that resuscitation effort was really quite a bit more than just a discussion. Would I be incorrect if I used the word in argument?

A. They were bickering about the pacemaker.

THE COMMISSIONER: I'm sorry, what?





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THE WITNESS: Bickering.

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THE COMMISSIONER: Bickering, yes.

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MR. TOBIAS: Q. Well, what I understand  
by bickering is that clearly we can agree there was  
a disagreement between the two of them?

6

A. There was a disagreement, yes.

7

8

Q. Okay. And if I elevate that  
and call it a heated debate would I be going too far?

9

A. I would say so, yes.

10

11

Q. Okay. And if I took it all  
the way up from a heated debate to an out and out  
argument would I again be taking it too far?

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THE COMMISSIONER: Wait a minute,  
I think we haven't got up to that.

14

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MR. TOBIAS: Well, I suppose it  
depends how you characterize it. I would call an  
argument something more than a heated debate.

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THE COMMISSIONER: Well, I know,  
but --

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MR. TOBIAS: A heated debate is  
almost sportsmanship.

20

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THE COMMISSIONER: Well, I think  
the witness wouldn't go as high as a heated debate,  
or would you?

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THE WITNESS: No.

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THE COMMISSIONER: No, you wouldn't go that high. So, if you consider an argument higher than a heated debate I think I can answer for the witness.

MR. TOBIAS: Well, we will use your scale, all right.

Q. In any event, would you use the word argument or heated debate?

A. No, I wouldn't.

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Q. Now the other day, and this  
appears at page 4213, Volume 107 --

A. What page?

Q. 4213.

THE COMMISSIONER: 4210 or 4213?

MR. TOBIAS: 4213.

Q. The question put to you by  
Mr. Lamek was:

"Q. Was there any conflict or  
disagreement between nurses on that  
occasion, that you observed?"

"A. Yes, there was some bickering  
between Susan Nelles and Phyllis  
Trayner."

Now I take it from that there is  
absolutely no question that what we had was a conflict  
because you didn't object to Mr. Lamek's use of that  
word. Do I have that correctly?

A. There was a conflict, yes.

Q. And have you ever before  
given evidence wherein you failed to object to the  
characterization of that event as an argument?

THE COMMISSIONER: Excuse me. I am  
lost on that question.

THE WITNESS: I am too.





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MR. TOBIAS: Well let me put it directly.

Q. Do you recall --

THE COMMISSIONER: Do you recall any evidence in which you failed to object -- did somebody once put it to you that there was an argument and that you conceded?

MR. TOBIAS: Yes.

THE COMMISSIONER: Is that what you are saying?

MR. TOBIAS: Yes.

THE COMMISSIONER: Well, do you mind --

MR. TOBIAS: I will put it more directly.

Q. You recall giving evidence at the preliminary hearing of Susan Nelles?

A. Yes.

Q. And you recall being asked certain questions by Mr. McGee and Mr. Cooper regarding this particular incident? Do you?

A. I would just like to refer to my copy. Do you know the page?

Q. Yes. It is Volume 7 of the preliminary hearing, page 1730.





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You were asked a very direct question,  
starting at line 14:

"Q. Did you ever hear any arguments  
between Susan Nelles and any members of  
the team that she was on?"

"A. Yes, sir."

"Q. And who was doing the (for  
the second time) arguing and what  
were they (for the third time) arguing  
about?"

"A. Sue and Phyllis were having  
an argument (that is your use of the  
word) of some sort during one of the  
arrests. It was about something that  
was going on. I didn't pay too much  
attention to it but they were bickering  
back and forth. One of the doctors  
said, all right, now, ladies, calm  
down, and they laughed about it later."  
Clearly on that occasion you as well  
didn't find it offensive to use the word "argument".

A. I used it then but I also  
used the word "bickering".

Q. Yes, I recognize that.

Looking back at it now, however, in





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light of that particular passage, would it still be  
unfair of me to characterize it as an argument in  
your view?

4

5

A. It is semantics I would  
say. I would still go that it was --

6

7

Q. In any event whether we call  
it an argument or bickering or debate --

8

9

MS. McINTYRE: I don't believe that  
the witness finished her answer to that question. I  
think you interrupted her.

10

11

MR. TOBIAS: I apologize, Miss  
McIntyre.

12

13

Q. Please forgive me, Miss  
Coulson.

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A. I don't know -- I can't  
remember what I was going to say.

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MR. TOBIAS: Well, you see it was  
okay anyway because I got her off the hook. She  
didn't remember.

18

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THE COMMISSIONER: I wonder if we  
could ask --

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MR. TOBIAS: She should be thanking  
me for the interruption.

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THE COMMISSIONER: -- perhaps how  
she would describe this present --

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HH5

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MR. LAMEK: Bickering.

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THE COMMISSIONER: -- bickering or  
argument.

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MR. TOBIAS: Q. In any event it  
is fair to say regardless of whether we call it  
bickering or arguing, you have a clear recollection  
that at one point the debate got loud enough that it  
did become necessary for Dr. Costigan to ask the  
ladies to quiet down?

10

A. He did say that, yes.

11

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Q. And he not only used the  
words, "Quiet down, ladies", but I believe the  
evidence you gave at the preliminary hearing was he  
said he asked them to calm down. So there was obviously  
some agitation there. Do you agree with that?

15

A. That is what I said.

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21

And you also gave evidence yesterday  
to the effect that whatever it was, bickering or  
an argument or a discussion or a debate, it really  
doesn't matter how we characterize it, but it didn't  
go on for too long. Do you recall that evidence?

22

I believe your exact evidence was  
a couple of minutes.

23

A. It wasn't long.

24

25

Q. All right. And first of all





HH6 1  
2 who else was at the resuscitation effort? Do you  
3 recall what other people were there?

4 A. There would have been an  
5 anaesthetist, a surgeon, some other nurses there.

6 Q. All right. Do you recall  
7 who those nurses were? Obviously two of them had to  
8 be Trayner and Nelles.

9 A. That is right.

10 Q. We can agree on that.

11 A. I think Bertha Bell was there.  
12 I am not sure who was recording.

13 Q. And do you recall who it was --  
14 you don't recall who was recording?

15 A. No, not off hand.

16 Q. All right. If I showed you  
17 a signature would that assist you at all?

18 A. Probably.

19 MR. TOBIAS: In Exhibit 103B, Mr.  
20 Commissioner, which is the Zebra package for Jordan  
21 Hines, there appears to be a handwritten note of the  
22 list of drugs given.

23 Q. Am I correctly identifying  
24 that? Is that --

25 A. List of drugs.

Q. -- the list that is kept during





HH7

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the resuscitation effort? And do you recognize the  
signature at the bottom of the third page of the note?

A. It looks like Dr. Soo.

Q. Was that a doctor and not a  
nurse?

A. Yes.

Q. And that doesn't help you at  
all with respect to who was recording?

A. That is right.

Q. Was Meredith Frise at the  
resuscitation effort?

A. Yes, she was.

Q. Would it surprise you if I  
advised you that she gave evidence at the preliminary  
inquiry for Susan Nelles that this debate lasted some  
20 minutes to one half hour?

A. Would it be a surprise?

Q. Yes.

A. Yes.

Q. Would you be surprised to  
learn that that was her time estimate?

A. Yes.

Q. Would you disagree with that  
time estimate?

A. Yes.







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Q. You would say it was much shorter than that in your own memory?

A. From my memory, yes.

Q. All right. Fine.

Now after Dr. Costigan asked them to calm down and be quiet, did they stop?

A. Yes.

Q. Can you tell me this: In a resuscitation effort when a pacemaker is called for, I take it that the doctor doesn't specify what kind of pacemaker he wants?

A. It is not a usual practice to ask for a pacemaker.

Q. Well, all right. How would the nurses know to go and get one?

A. Well --

Q. Who would issue the order?

A. A doctor would ask for a pacemaker.

Q. All right. And when he would ask for a pacemaker, would he say what kind?

A. He might.

Q. All right. Obviously in this case I take it that he didn't.

A. I guess not.





HH9

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Q. Do you recall if he did?

3

A. I don't remember.

4

Q. And is there any difference  
in terms of rank or seniority in an arrest situation?  
In other words would Phyllis Trayner have more  
authority because she was team leader?

5

6

7

A. A little.

8

9

Q. And would it be her who would  
decide what kind of pacemaker should be brought?

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11

A. I don't think it is her  
decision, no.

12

Q. Whose decision is it?

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A. It depends on where the  
pacemakers are and if they want a pacemaker fast, you  
get the closest pacemaker.

15

Q. Regardless of the type?

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A. And if he wants a specific  
kind, if the doctor wants a specific kind, then he  
would ask for it. Otherwise the nurse that goes to get  
the pacemaker would get a pacemaker.

20

Q. All right.

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The point is if he calls for a pace-  
maker, the correct procedure is to get it as quickly  
as you can, whatever is available?

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A. I would think so, yes.





HH10

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Q. Especially where he hasn't particularly specified which kind he wants?

A. Yes.

Q. Would you agree with that?

I take it then, and please correct me if I am wrong, would you agree with me that in effect then this was really not an appropriate time to bicker about the type of pacemaker to bring or to engage in the kind of discussion that was engaged in?

A. I would agree.

Q. In fact that is why you spoke to the nurses and that is what you indicated to them shortly after?

A. Yes.

Q. And would you agree with me that in effect the fact that that discussion ensued does show somewhat - and I am not saying a major, okay, I don't claim to editorialize or characterize the nature of it - but it shows somewhat, be it major or minor, a lack of judgment at that particular time; would you agree with that?

A. On both parties, yes.

Q. And with respect to your evidence the other day that you didn't feel that the Hines resuscitation effort was in any way prejudiced by





HH11

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this discussion, I am not challenging, you understand, but I would just like to know on what facts do you base that. Why do you think it was not in any way prejudiced or hampered?

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A. Because the child -- people were still working with the child. It wasn't as if attention had been taken away from the baby.

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Q. But you agree with me enough attention was taken away, even if for just a brief moment, that Dr. Costigan who was in charge of the resuscitation effort had to ask the nurses to keep it quiet?

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A. Yes.

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Q. And it obviously, if it irritated him - or I shouldn't use the word "irritated", I am imputing an intent and an emotion to him - but if it caught his notice, can I take it it must have caught other people's notice and in that event wouldn't you agree with me that it had to in some small way interfere with the efforts other people were making?

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MR. BROWN: Well, did it in fact catch the attention of other people? I think that would have to be proved.

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THE COMMISSIONER: Well, it caught the attention of the doctor. I think that is all --







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MR. BROWN: I believe Mr. Tobias is referring to other people in addition to the doctor.

THE COMMISSIONER: Oh, yes.

MR. ROLAND: Dr. Costigan has already testified here about that, but none of that was put to him.

The interesting thing, Mr. Tobias introduces his line of questioning by saying I am not going to suggest for a moment that it affected the resuscitation but then he proceeds to try to convince the witness otherwise. I don't know what he is up to. And that is how he introduced the whole line of questions.

MR. TOBIAS: I believe what I said, and the record will show what I said, I am not attempting to characterize whether it was a major or a minor interference. I don't think I ever suggested that I wasn't --

THE COMMISSIONER: I think the objection is that it caught the attention of other people.

MR. TOBIAS: Okay. Let me ask the question directly.

Q. Did it catch the attention of other people?





HH13

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A. It caught my attention.

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Q. Anybody else that you can

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recall?

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A. I can only speak for myself.

6

Dr. Costigan and myself.

7

Q. You can only tell us that

two people's attention was caught by it?

8

A. That is all I can answer for,

9

yes.

10

Q. All right. Fine.

11

And anyone else who may have testified

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about it or given information about it, obviously knew

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about it, so their attention must have been caught as

well.

14

A. I can only --

15

Q. Do you agree with that?

16

A. I can only speak for the

17

ones I know.

18

Q. No, but if I told you another

19

nurse had been here and testified about it, we must

20

assume that obviously it caught her attention as well?

21

A. That makes sense.

22

Q. Would you agree with that?

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Now, the other day you told Mr. Lamek

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in your evidence in chief that it was about the second

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week of March 1981 when it entered your mind for the very first time that somebody might be causing these deaths.

Do you recall giving that evidence?

THE COMMISSIONER: We went through that before, and I think it came out that something, not someone, but maybe I am wrong.

MR. TOBIAS: Well, in fairness, Mr. Commissioner, it appears at Volume 106, page 4132 of the transcript -- the ultimate ploy. Someone has stolen my transcript. This is like a man drowning, Mr. Commissioner.

Mr. Roland threw me a lifeline. Thank you, sir.

I believe that it did come out later, at 4135, there was a discussion. The first reference was to somebody.

THE COMMISSIONER: I haven't checked it out, but we attacked poor Miss Coulson about the thing, and I think she made it clear that something was happening and then at a later time it was somebody. The somebody didn't come until after knowledge of the presence of the police.

Isn't that right?

THE WITNESS: I didn't suspect any one







HH15

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person until after. Is that what you said?

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THE COMMISSIONER: That is not quite what I said. You suspected something was happening.

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MR. TOBIAS: All right. If I could be of assistance.

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The first reference, Mr. Commissioner, was at page 4132 and the question was:

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"Q. Did you at any time, Miss Coulson, prior to late March or 1981 entertain the thought that somebody might be causing the deaths by accident or otherwise?"

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"A. That thought did enter my mind."

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Now, at page 4140 the issue was raised by again Mr. Lamek:

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"Q. Had that thought occurred to you that someone, in some way or another, might be causing those deaths, occurred to you at any time before the latter part of March?"

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22

"A. I would have to say that some thing was happening. I couldn't say that some one."

23

24

And again at page 4141 Mr. Lamek asks

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HH16

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the question:

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"Q. But if really pressed you  
would have to say that means probably  
some one?"

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"A. It looks that way, yes."

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And I think that is the last reference  
to it.

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MS. MCINTYRE: Mr. Commissioner, in  
fact there was a further reference to it. When I  
asked Miss Coulson some questions at page 4257 and I  
clarified -- I referred back to precisely the question  
by Mr. Lamek --

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THE COMMISSIONER: Yes. Well, I think  
by all means let's refer the witness to that one, but  
I want to tell the witness this isn't a debate as to  
what you said. The real interest we have is what you  
now remember, and if you made a mistake yesterday or  
if you want to correct it or -- don't worry too much  
about what you said. Just try to help us out now  
as to before you heard about the police coming on the  
scene, just after the spate of deaths in mid-March  
and the question at the time that Mr. Lamek was asking,  
"Did you think that someone or something was  
happening to the children?"

THE WITNESS: I knew that --





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THE COMMISSIONER: Or did you think  
either? Because you don't have to think either.

THE WITNESS: I knew that something  
was happening to the babies, but I didn't know what it  
was.

THE COMMISSIONER: They were dying  
for one thing.

THE WITNESS: They were dying but I  
didn't know why.





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THE COMMISSIONER: But you thought it was, please don't let me lead you here, but you thought it was something unnatural. By that I mean, there were suspicions later that there was something wrong with the digoxin. Do you follow me, something was happening to them, do you mean something unusual?

THE WITNESS: Something unusual was happening to the babies, yes.

THE COMMISSIONER: It has probably not helped your cause at all.

MR. TOBIAS: Well it helped somewhat.

Q. Let me ask you this. The first time that that occurred to you that it was something unnatural, would that have been, and I won't give you dates, but I will ask you this, do you recall today whether that thought crept into your mind before or after the arrest of Jordan Hines?

A. Oh, I can't answer that, I don't know when it occurred.

Q. I take it then that it is as likely that it could have been either before or after?

A. Sure.

Q. Now, when that thought occurred to you for the first time, was it a thought that stayed with you, did you continue to think about it







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for some time, or did it just enter your mind and then you totally forgot about it and went on about your business?

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A. I don't remember.

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Q. At any time after that first occasion when it dawned on you, did it re-enter your mind and in particular I am talking about your conversation with Mrs. Johnstone on either March 23rd or 24th, when you knew that the police were in the Hospital investigating? Did the thought then reoccur that something unnatural was happening?

12

A. Yes.

13

14

Q. And at that point, because you knew that the police were there, and I think you said that means murder, you used that word?

15

A. Yes.

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Q. Obviously at that point in time you were now considering, be it for the very first time or the second time, it really doesn't matter, you were now considering the question of someone, it was not only something unnatural happening, but you had to entertain in your mind the possibility that someone was doing something to these babies, do I have that correctly?

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A. That night, the Tuesday night?

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II.3

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Q And can you also agree that having entertained in your mind the question that someone might be involved, it would only be natural I take it that your mind must have also turned to who could that someone be?

A Yes.

Q And you obviously had some thought about that?

A Yes.

Q And all of this I take it happened very suddenly upon learning that the police investigation had started, and in light of the somewhat shocking events of March 21st, 22nd, with the digoxin being locked up; do I have that correctly as well?

A Taking all those events and putting them together, yes.

Q And it was a shock, obviously, it is not something that you think about every day, is it?

So I take it, and I don't suggest that you were obsessed by the thought, but you must have given it more than casual consideration, it didn't just enter your mind in a fleeting moment and then disappear, it is something you obviously must





II.4

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have paid some attention to?

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A. I can't remember exactly what

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my thought process was at that time.

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Q. And do I have it correctly as

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well that you were looking at it from the history of  
the whole matter that had taken some nine months to  
unfold?

8

A. Yes.

9

Q. Now ordinarily you don't keep

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tabs do you on which nurses are working on which nights?

11

A. Oh no.

12

Q. Could you tell me for instance

13

even today, in that nine-month period, how many nights  
Sui Scott worked?

14

A. Not unless I looked at the records.

15

Q. No, but without doing the

16

calculation could you tell me that now?

17

A. No.

18

Q. Could you tell me without looking

19

at the records right now how many nights during that  
nine-month period Susan Nelles worked?

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A. She worked a lot of them.

21

Q. Can you tell me the specific

22

number?

23

A. No, I can't.

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II.5

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Q Can you tell me the specific  
number that Phyllis Trayner worked?

4

A No, I can't.

5

6

Q Can you tell me even today the  
number of deaths that Phyllis Trayner was on duty for?

7

A No.

8

Q Can you tell me the number with  
respect to either Nelles or Scott?

9

A No.

10

11

Q I take it back then you couldn't  
have told me that either?

12

A That's right.

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Q And in fact your recollection,  
what was it, were they almost equal in terms of the  
number of nights they had worked; were there horrendous  
differences between the number of times they had  
worked at night?

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A I remember various people being  
away on vacation when it was the night shift, so that  
would take away from their being on.

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(2)

21

Q As between Scott, Nelles and  
Trayner then?

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A I remember Phyllis getting  
married in the fall and being away for a couple of  
weeks. I remember Sui being away for a couple of  
vacations.





II.6

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Q. But you really had no hard knowledge with respect to who was there most often, or more often, or what the degree of difference was, did you?

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A. As far as specific numbers, no.

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Q. Okay. I find it interesting that when you first found that the police investigation had started, and you had that discussion with Lynn Johnstone and you were upset, you were shaking, and the thought crossed your mind that somebody might be involved and you started to think of potential actors or actresses. I find it interesting that at that time the first thought that came to your mind that it had to be one of two people, why one of two people? Why not one of four people, or five people, or six people, why zero in on two?

17

A. I don't know.

18

19

20

21

Q. Well you have given evidence here that it was because of the presence of those two people, but there must have been other people who were present almost as much, why didn't you think of them?

22

23

24

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A. That is what I don't remember.

I remember that those two people came to mind first, and I don't know why they came to mind other than





II.7

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their presence. I can't tell you why I didn't think  
of the other people.

3

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Q But you told Miss Forster  
yesterday that the only reason why Phyllis Trayner  
came to mind was her presence?

5

6

A Yes.

7

8

Q She was there for a lot of the  
arrests?

9

A Yes.

10

11

Q Are you not telling me today  
that might not have been the only reason, it is just  
that you can't remember any other reason?

12

13

A She came to mind because of her  
presence?

14

15

Q And might there be some other  
reason why she came to mind that you can't remember now?

16

17

A There might have been, but I  
don't remember.

18

19

Q And with respect to Phyllis'  
behaviour over that nine-month period, we have heard  
a lot of evidence about her preoccupation with the  
arrests, and concern over the arrests, a need to be  
reassured, a need to talk about it. Was that one  
of the reasons perhaps why she came to your mind?

20

21

22

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A No, I never saw that behaviour.

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II.8

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Q. Were you aware of it?

3

A. I heard people talking about it  
4 but I never noticed.

5

Q. As far as you are aware today  
6 that would have no - or that had no significance in  
7 bringing her to mind?

7

A. Not to me, no.

8

Q. Isn't the bottom line then, in  
9 fairness, and please correct me if I am summarizing  
10 incorrectly, that these two people came to mind  
11 partly because of their presence, and you can't think  
12 of any other reason why they did come to your mind?

12

A. Their presence, yes.

13

MR. TOBIAS: Thank you, those are all  
14 my questions.

15

THE COMMISSIONER: Yes, thank you.

16

Miss McIntyre, I won't call on you but  
17 how long do you think you will be?

17

18

MS. MCINTYRE: I don't anticipate being  
19 too long, Mr. Commissioner.

19

20

THE COMMISSIONER: All right. Well,  
21 Mr. Lamek, on that basis I think we should rise now,  
22 unless you and Miss McIntyre can finish it in ten  
23 minutes?

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MR. LAMEK: Before 5 o'clock?

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II.9

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THE COMMISSIONER: No.

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MR. LAMEK: No, I don't think that is

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likely.

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THE COMMISSIONER: All right, we will

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rise until 10 o'clock, and you having that information

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you can arrange the next witness accordingly.

8

MR. LAMEK: Thank you, sir.

9

THE COMMISSIONER: All right, until

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10 o'clock tomorrow.

11

--- Whereupon the hearing was adjourned at 4:40 p.m.  
until 10:00 a.m., Thursday, February 23rd, 1984.

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